Exhibit 1

February 22, 2019

RE: Campbell Hatch
DOB: 04/19/2002
Request ID: 18275AAED3
Subscriber ID: 827820223

To Whom It May Concern,

It was recommended to us to send Campbell to a residential treatment program by both her licensed therapist and her psychiatrist. Campbell was experiencing low self-esteem, low self-worth, she was struggling with her peer relationships, school, and her overall value. We adopted Campbell when she was an infant, and while it was something we discussed on a regular basis, it was never something Campbell accepted.

By the time she was admitted into Paradigm, she was cutting on a regular basis, having anxiety attacks that caused temporary paralysis in her arms and legs, blindness and left her in a catatonic state for a period. The professionals at Paradigm did not feel that Campbell was ready to come home at the end of 30 days and recommended that she stay for an additional 15 days. She had been on suicide watch.

While Campbell had a break through at Paradigm with her adoption and coming to terms with that, she was continuing to engage in thoughts that were not based, claiming that she was bulimic and exercised until she lost the weight she wanted, and yet with her scoliosis the pain in her back didn't allow her to exercise to that extent. In reviewing her diary from Paradigm, while she may not have openly discussed suicide ideation, she openly wrote about it and discussed how empty she felt. Her anxiety was still unregulated, and she picked at her skin to the extent she would claw herself and draw blood. This is not normal behavior.

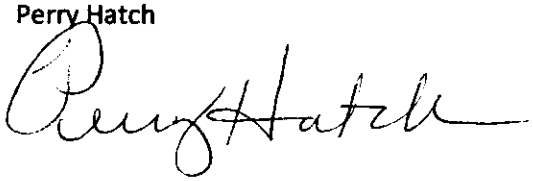
When Campbell did come home, she quickly spun out of control. She tried to OD on Adderall. The Hillside IO/PHPP program we enrolled Campbell in discharged her due to an outburst and self-harming herself. They sent her to the ER for an evaluation in hopes for her to be admitted into a stabilization facility. The psychiatrist at Hillside felt Campbell needed to go back into a residential program.

I would respectfully like you to review Campbell's case and reconsider covering her stay at Paradigm for the last 15 days Oct 30 – Nov 13, 2018.

Please let me know if you need any other information from me or the team at Paradigm.

Sincerely,

Perry Hatch



BlueCross BlueShield of Illinois

EXTERNAL REVIEW REQUEST

You may request external review, at no cost to you, for the following:

a. An adverse determination or denial that involves medical judgment including a decision that the requested health care services are experimental or investigational;

b. A determination on whether you are entitled to reasonable alternative standard for a reward under a wellness program;

c. A determination on whether your Plan is complying with the non-quantitative treatment limitations that require parity in the application of medical management techniques; and

d. Rescission of your coverage

Standard ☐

Expedited ☐ **You can call 800-538-8833 to request an expedited external review at the same time you request an expedited internal review.**

Today's Date: 2/22/19

Subscriber's Information	**Patient's Information**
Name: Jett Perry Hatch	**Name:** Campbell Arlene Hatch
ID:	**ID:**
Address: 1102 Menlo Way NW Kennesaw GA 30152	**Address:**
Phone Number:	**Phone Number:**

Have you already received these health services? ✓ Yes ____ No

If yes, when were the services received? (Month / Day / Year) 10/30 – 11/13/2018

What was the Claim Number? 18275AAED3 Requester ID

See attached Subscriber ID 827820223

Please state the reason you believe the decision was not correct:

20181107B09 J916 Env [1,810] 7 of 7

ILAPPEALS

20181106 001215

Urgent Care Claims

If your health may be in serious jeopardy or, in your doctor's opinion you may have pain that cannot be controlled while you wait for the external review decision, you may ask for an expedited review by having your health care provider call us at 800-538-8833 or fax your request to 972-907-1868.

Rescission of Coverage Claims

A rescission is the retroactive cancellation of your coverage.

Is this request for external review of a rescission? _____ Yes _____ No

We will notify you within 5 days of receiving your request, whether your request is eligible for external review or whether additional information is needed to make that determination.

If your request is eligible for external review, an Independent Review Organization will be randomly assigned. You will receive notice from the assigned IRO that will include information on where to send any additional documents. You will have 10 business days to submit additional documents to the IRO.

We will provide to the IRO, within 5 business days, all documents that were considered in our review.

The IRO will complete an expedited review within 72 hours after assignment and will complete a standard external review within 45 days after assignment. You will receive written notice of the decision from the IRO.

The decision is binding except to the extent there are other remedies available under applicable law. If the IRO overturns our decision, we will provide coverage and or payment for the claim subject to any member share for deductible, co-insurance and co-payments.

Please sign and date the form:

Signature: Perry Hatch Date: 2/22/19

Printed Name: Perry Hatch

I am the: ☐ Covered Person ☒ Parent or Legal Guardian ☐ Authorized Representative ☐ Provider of Record

Authorized representative: You can represent yourself, or you may ask another person, to act as your authorized representative. You may revoke this authorization at any time.

I, _____ hereby authorize _____.

to pursue my external review appeal on my behalf.

_____ Date: _____

Signature of Covered Person or Legal Representative

NOTE: The covered person must sign this form, unless they have a legal guardian, personal representative, are incapacitated, or have otherwise delegated authority to complete this form.

Please send any additional clinical information to support your request for external review along with this form to:

BCBSIL – External review request
PO Box 2401
Chicago, IL 60690

or

Fax: 972-907-1868

BlueCross BlueShield of Illinois

IMPORTANT UPDATES ENCLOSED

Subscriber Name :
Member Name : CAMPBELL HATCH
Member Address : 1102
MENLO WAY NW
KENNESAW, GA 30152-6986
Request ID : 18275AAED3

November 06, 2018

Dear CAMPBELL HATCH:

This letter is in response to a request for benefits for service(s)/procedure(s). The request, along with the available medical information was carefully reviewed. **Benefits for the service(s)/procedure(s), as described below, have been denied.**

Member Name:	CAMPBELL HATCH
Subscriber ID:	827820223
Physician:	CHELSEA NEUMANN
Facility/Provider:	PARADIGM MALIBU
Treatment Setting:	Residential
Non-approved Date(s):	10-30-2018 - 11-06-2018
Number of Non-approved Day(s):	7

All information related to your request was received and reviewed by a Medical Director.

Reason: Requested service(s) does not meet clinical criteria, guidelines or standards of care for diagnosis

The clinical rationale for the denial of the request for benefit/service authorization is:

Per the medical necessity provision of your benefit plan, a medical necessity review has been completed. Based on the clinical information provided, you did not meet MCG Residential Acute Behavioral Health Level of Care (Child/Adolescent) Guidelines the following reasons. You are not having plan or intent to hurt yourself or anyone else. You are not hearing voices or seeing things that are not there. You are not hearing voices telling you to harm yourself or others. You are not aggressive or violent. There are no medical problems reported. No severe side effects from medications. From the clinical evidence, you can be safely treated in a less restrictive setting such as MCG Partial Hospital Behavioral Health Level of Care (Child/Adolescent). The last covered day is 10/29/2018.

Your physician/provider may contact the Healthcare Management Department at 1-888-898-0070 to discuss this case with a behavioral health physician advisor.

BHSPLX 20181107B03 J85C [DM] 001826 Env [10] 2 of 10
20181107

Criteria used in denying a request for benefit/service may include the MCG care guidelines, Health Care Service Corporation Medical Policy, American Society of Addiction Medicine's *ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition Revised (ASAM PPC-2R),* Blue Cross and Blue Shield Association Policy Reference Manual.

Licensee's use and interpretation of the American Society of Addiction Medicine's *ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition Revised (ASAM PPC-2R)* does not imply that the American Society of Addiction Medicine has either participated in or concurs with the disposition of a claim for benefits.

If the benefit determination involved a rule, guideline, protocol, other criterion or a medical necessity or investigational/experimental treatment decision, a copy of the rule, guideline, protocol or criterion, or explanation of the scientific or clinical judgment for the determination, will be provided free of charge upon request.

Information or criteria used in the decision-making process is available on request. Please contact us at 1-888-898-0070.

To request an internal appeal, please see the "Important Information" attachment for instructions. Appeals will be reviewed by a board certified practitioner of the same or similar specialty as typically manages the medical condition, procedure or treatment under review and who has not previously reviewed the case and is not subordinate to the initial reviewer.

If this is an urgent care request, an expedited appeal is available. Please see the "Important Information" attachment included with this letter and contact the Blue Cross and Blue Shield of Illinois (BCBSIL) Healthcare Management Department at 1-888-898-0070 to begin an expedited appeal.

If this is not an urgent care request, a standard appeal may be requested in writing, within 180 days of receipt of this notice. Please submit any supporting documentation, medical records or other information to be considered with the appeal request. See the "Important Information" and "Appeal Request and Procedures Form" for instructions on initiating an appeal of this decision. Members may also reference their Health Care Benefits booklet and/or Summary Plan Description for procedures related to filing claims, inquiries, complaints and appeals. Appeal requests should be submitted to the Appeal Department at the address listed on the "Important Information" attachment. You have the right to be represented in the appeal process by anyone you choose such as a family member, friend, attorney, and/or healthcare practitioner.

You have the right to have our decision reviewed by an Independent Review Organization not associated with us as identified below. Upon receipt of your request, an Independent Review Organization will be assigned to review our decision. See the "Important Information" attachment for instructions and more detailed information. There will be no cost to you for the IRO.

You may also have a right to an expedited external review. Please see the "Important Information" attachment.

If the member's benefit plan is governed by ERISA, the member or the member's authorized representative may have the right to take legal action under Sec.502 (a) of ERISA if the benefit decision is upheld on appeal.

The decision to receive the proposed service/procedure remains between you and your health care providers. Coverage, benefit and payment decisions do not constitute treatment decisions.

See enclosed attachments.

Sincerely,

Blue Cross and Blue Shield of Illinois
Health Care Management Department
Phone Number: 1-888-898-0070
Fax Number: 1-877-361-7656

Enclosures: IMPORTANT INFORMATION
Appeal Request and Procedures Form

CC: CHELSEA NEUMANN
6323 VIA ESCONDIDO DR
MALIBU, CA 90265

PARADIGM MALIBU
6323 VIA ESCONDIDO DR
MALIBU, CA 90265-4484

BlueCross BlueShield of Illinois

November 06, 2018

Subscriber:	Perry Hatch
Group/Sub. No.:	759903/000827820223
Claim No.:	NA
Appeal ID No.:	18275AAED3
Appeal Type:	Provider

Paradigm Malibu
6323 Via Escondido Dr
Malibu CA 90265-4484

Phone: (877)238-5944
Fax: (918)551-2011
Email: SDOAppeals@bcbsil.com

Subject: Your appeal results

Dear Paradigm Malibu :

We received your appeal on November 06, 2018, for the denial of the below treatment or service(s).

The appeal and the related medical records you gave us have been reviewed by a Physician Reviewer that is a M.D. who is board certified and specializes in Psychiatry. This doctor was not involved in the prior denial.

Appeal Decision	After careful review of the information we have, the appeal request has been **denied**.

Service(s)	Mental Health Residential Treatment		
Member	Campbell Hatch	Provider	Chelsea Neumann, Md
Service Date(s)	October 30, 2018 - November 6, 2018	Facility	Paradigm Malibu
Initial Decision	Certification/approval is required from mental health advisor for the treatment of mental health or substance abuse conditions benefit payment denied because mental health advisor was contacted but did not approve the treatment received.	Initial Decision Code	754
Initial Decision Date	November 02, 2018	Claim Amount	$

BlueCross BlueShield of Illinois

November 06, 2018

Subscriber:	Perry Hatch
Group/Sub. No.:	759903/000827820223
Claim No.:	NA
Appeal ID No.:	18275AAED3
Appeal Type:	Provider

Paradigm Malibu
6323 Via Escondido Dr
Malibu CA 90265-4484

Phone: (877)238-5944
Fax: (918)551-2011
Email: SDOAppeals@bcbsil.com

BH Non-Clinical Appeals Coordinator

Appeals Department

Cc: Campbell A Hatch
Chelsea Neumann, Md

Attachment:
Triage IL Addenda- ASO Federal UGF
Triage IL Federal IRO form

paradigm TREATMENT CENTERS

February 8, 2019

RE: Campbell Hatch
DOB: 07/19/2002

To Whom It May Concern:

My name is Emily Armour. I am a Licensed Clinical Professional Counselor and Program Director at Paradigm Treatment Centers – Point Dume. I am writing on behalf, and at the request of our client Campbell Hatch (DOB: 07/19/2002) and her family. Ms. Campbell was admitted to our residential treatment facility on September 30, 2018 and discharged on November 13, 2018, completing a 45 day stay. We are writing to assist the family in obtaining the necessary coverage for the entirety of her stay as well as the necessity of ongoing treatment.

Campbell was experiencing low self-esteem, low self-worth, psychosomatic symptoms of pain related to scoliosis surgery in January 2018 that left her in catatonic states, temporary blindness, and pain so severe she would be in the emergency room. She also was experiencing severe academic and social difficulties, self-harm (cutting), high risk sexual behaviors, anxiety, depression and maladaptive social interactions prior to her admission to Paradigm. These issues led to a significant decline in her overall daily functioning. She presented with a history of risky behaviors, suicidal ideation, reported substance use, impulse control problems, failed outpatient treatment attempts, and attachment issues. All these aforementioned issues put Campbell's overall physical and mental health at high risk. Due to Campbell's decline in ability to manage her mood and impulsivity, Campbell quickly became unable to effectively manage her overall functioning, and due to her history of risky behavior put her in danger and an increased likelihood of significant harm. The client's history and precipitating events made it very clear that it was medically necessary for her to be placed in a 24-hour care facility.

Upon her enrollment, Campbell was diagnosed with the following:
F33.2 Major Depressive Disorder, Recurrent Episode, Severe
F41.1 Generalized Anxiety Disorder
F90.2 Attention Deficit/hyperactivity disorder, Combined Presentation
Borderline Personality Traits
Rule Out: RAD, PTSD, Conversion, Unspecified Eating/Feeding Disorder

Campbell's treatment consisted of a psychiatric evaluation and ongoing assessment and medication management with our Board-Certified Child and Adolescent Psychiatrist. She also participated in an initial psychological evaluation and ongoing psychological assessment with a Licensed Clinical Psychologist, both of whom supervised and informed her treatment. She participated in daily individual therapy sessions, weekly individual family sessions, family group therapy sessions, as well as a variety of psycho-educational, experiential, process, and other group therapy sessions which occurred three to four times daily. During Campbell's stay, it was noted the importance and significance of medication and psychotherapy to manage her symptoms, which was addressed and within her stay it was observed that medication and significant amounts of psychotherapy were pertinent to her reduction of symptoms and

paradigm TREATMENT CENTERS

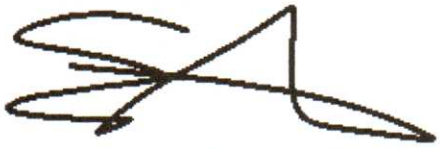
Campbell experienced an upswing in overall functioning and ability to interact with peers, herself, and her family.

Campbell was covered for the initial 30 days of her treatment and then was denied further coverage though her needs for ongoing 24-hour care were immediate and withstanding due to her presentation of symptoms, significant mental health history, and ongoing endorsement of mood instability. Campbell and her family attempted to seek appropriate outpatient services and demonstrated no success. When the family moved, appropriately, to seek specific, intensive, insight-oriented residential level of care (as advised by outpatient providers to treat this patient), the family's access to care was questioned in the early stages of her program. The need for ongoing care and coverage beyond the covered days is pertinent to the client's well-being. The severity of Campbell's case and ongoing need for treatment, if not addressed and supported, sets the stage for very bad things to happen and future hospitalization and costs in the future. We will be acting in full support of this family in their appeals in this case.

It remains our professional opinion that Campbell met appropriate clinical criteria for 24-hour supervision and care for the duration of her 45 days at Paradigm.

If you have any additional questions, feel free to contact me at your convenience.

Kind Regards,



Emily Armour, MS, LPCC, NCC
Program Director

Biopsychosocial Assessment

Demographics

Date: 09/30/2018 **Admit Date:** 09/30/2018 **Time Begun:** 3:48pm **Time Ended:** 5:05pm

Presenting Problem:

Client Name: Campbell Hatch **Patient ID#:** 10167

Address: ,

Telephone (Home): **Cell:**

Date of Birth: 07/19/2002 **Age:** 16 **Sex:**

Email:

Social Security #:

Emergency Contact Information

In case of an emergency, contact - Name: Perry and Paul Hatch

Telephone #: (404) 907-6283 **Relationship:** parents

Address: 1102 Menlo Way, Kennesaw, GA 30152-6986

Name of Primary Care Physician (PCP): Dr. Amy Harden

Telephone # of PCP: not known

Address of PCP: not known

Drug Allergy: none reported

Food Allergy: gluten intolerant/sensitivity

Descriptive Information

Height (in): 5

Height (ft): 3 **Weight:** 110 lbs **Eye Color:** blue **Hair Color:** brown

Race: ○ African American/Black ○ American Indian or Alaska Native ○ Asian ◉ Caucasian/White ○ Hawaiin or Pacific Islander ○ Other

Ethnicity: ○ Hispanic ○ Not Hispanic ◉ Other

If Other: Puerto-Rican and French

Any identifying physical characteristics (scars, tattoos):
smalls scars on knees from surgery; large scar down spine from back surgery from scoliosis; pierced ears

Have you been in a controlled environment in the last 30 days: ◉ No ○ Yes

Precipitating Event:

Pain Assessment:

Are you experiencing any pain? ○ No ◉ Yes

If yes, assess: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ◉ 7 ○ 8 ○ 9 ○ 10

Current/Past Medications:
*Per client's report)- with back issues says there is commonly pain experienced, but says she tolerates it okay. Currently takes Advil for pain, in the past Oxycodone and Valium for back pain after surgery (in Jan. 2018 for a few

weeks); says occasionally takes Valium (if the back spasm is bad enough to help it relax); taking birth control (Lo Loestrin Fe- has not started pack yet, waiting for menstrual cycle to start); calcium pills; Zoloft (200mg nightly); during school takes adderall

Substance Abuse History

	Current Usage Past 30 Days	If yes, pattern of use last 30 days (include amount and frequency)	Age of 1st Use	Age this became a problem?	Pattern of use for at least last 6 months (include amount and frequency)	Primary Route:(Oral, IV, etc.)	Date, Time, and amount of last use
Alcohol	○ No ◉ Yes	4-5 times in the last month and enough to get drunk (maybe 4-5 shots worth)	14	doesn't consider a problem	4-5x/month over the past 6 months- says sometimes it is only a beer, sometimes drinks to get drunk	it or jello shots	a few weeks ago
Amphetamines	○ No ◉ Yes	takes Adderall as prescribed during school- but not taken in a couple of weeks due to being kicked out of school and not going	since 2nd grade		usually takes as prescribed; a few times at a party would snort it with peers	oral; crushes and snorts when taken at a party	a few weeks ago
Barbiturates	◉ No ○ Yes						
Benzodiazepines	◉ No ○ Yes						
Xanax	◉ No ○ Yes						
Valium	◉ No ○ Yes	none recently	16		only as prescribed for back pain	orally	a few weeks to a month ago
Klonopin	◉ No ○ Yes						
Cocaine	◉ No ○ Yes		15		only took it once and didn't like it (felt weird)	snorted	about a year ago
Hallucinogens	◉ No ○ Yes						
Inhalants	◉ No ○ Yes						
Marijuana	◉ No ○ Yes	none in last 30 days	11	doesn't consider a problem (stopped on own after breaking up with boyfriend)	before this month, was at least 4-5x/week after school; would be 5grams/day	smoking and vaping	1-2 months

Methamphetamine	○ No ○ Yes						
Opioids	○ No ○ Yes						
Hydrocodone	○ No ○ Yes						
Oxycodone	○ No ○ Yes		16		only as prescrobed for backpain or after wisdom teeth		several months ago
Morphine	○ No ○ Yes						
Methadone	○ No ○ Yes						
Heroin	○ No ○ Yes						
Oxycontin	○ No ○ Yes						
Other opioid	○ No ○ Yes						
Bath Salts	○ No ○ Yes						
Designer Drugs	○ No ○ Yes						
Steroids	○ No ○ Yes						
Tobacco	○ No ○ Yes						
nicotine (vape)	○ No ● Yes	maybe 1x (1 hit) this past month	13	doesn't consider it a problem	before this month daily (several hits a day)	vaping	Friday night (9/28/18)

Drug of Choice 1 nicotine (vape) **Drug of Choice 2** Marijuana **Drug of Choice 3**

Chemical Dependence Treatment History

Have you ever been treated for a substance abuse issue? ○ No ○ Yes

If yes, list treatment below:

Client Directed Outcome Informed Screen

What are your expectations/outcomes from this treatment?
Maybe just better (initially said "I don't know")

What specific problems do you want to address while in treatment?
anxiety, depression, stress; working on fighting with Mom

Client's self reported:

Strengths:
drawing; singing; dancing (had to stop with spine surgery)

Needs:
couldn't identify any (even with assistance)

Abilities:
flexible (physically); cheer; archery, swimming; surfing

Treatment Preferences:
doesn't like family treatment (knows it is part of being here, but has a hard time being in the same room as parents talking about stuff)

Client's self reported problems and challenges:
my biggest struggle is not being able to dance competitively since back surgery (feels like it is making her really depressed); dealing with break up from ex-boyfriend (of 6 months) that happened a couple weeks ago

Client's self reported interests and activities:
dance (can't do this one as much since surgery), cheer, records and makes/edits videos, draws, runs, exercise, animals, the beach

Has there been any change in these interests and activities as a result of substance use: ◉ No ○ Yes

List other people that you would like to be involved in your treatment and their relationship to you:
parents, sister, would like a friend (knows though that treatment is family focused and friend might not be included in calls and visits)

Confidential Releases of Information signed? ○ No ○ Yes

Emotional/Behavioral

Have you ever been given a psychiatric diagnosis? ○ No ◉ Yes

If Yes, diagnosis
MDD, anxiety, bulimia (per client's report), ADHD

Who made the diagnosis: last therapist (couldn't remember her name) **When?** several months

Have you received mental health services or are you currently receiving services? ○ No ◉ Yes

If Yes, list treatment below:

MH Treatment Provider/ Facility	Date of Treatment	Level of Care	Duration of Treatment	Diagnosis or reason in treatment
Keeley Bailey (EMDR therapist)	a month ago	outpatient therapy 1x/week	only went 1 time due to getting mad and not liking the EMDR	just have always gone to therapy (couldn't identify a main reason other than what has always brought her to treatment since the beginning which is losing her Godfather 5 years ago)
therapist (can	several years ago	outpatient therapy 1x/week	2-3 months	went after losing Godfather
psychiatrist (Suzanne Starky)	maybe 1-2 years	psychiatry	sees 1x/month	depression, anxiety, ADHD

Other details

If Yes, please explain:
reports being bulimic- will eat, then exercise and exercise until she goes back to 98 lbs. (started Sept. 2017- only identifies trigger being not wanting to gain weight, but doesn't know why); says she doesn't eat a lot in general (maybe 2-3 bites, sometimes more) but that is due to low appetite; maybe started a year ago

Are you concerned you may have an eating disorder? ○ No ◉ Yes

Have you ever been treated for an eating disorder? ◉ No ○ Yes

Are you concerned you may have a gambling issue? ◉ No ○ Yes

Have you ever been treated for a gambling issue? ◉ No ○ Yes

Are you concerned you may have sexual compulsivity? ◉ No ○ Yes

Have you ever been treated for sexual compulsivity? ◉ No ○ Yes

Are you concerned you may have trauma issues: ◉ No ○ Yes

Have you ever been treated for traumatic issues: ◉ No ○ Yes

Are you interested in treatment for your mental health issues? ○ No ◉ Yes

Post-Admission Safety Assessment

Section I: Suicide Screening

Current suicidal thoughts? ◉ No ○ Yes, Passive ○ Yes, Active

If Yes, what is the plan, intent or means to accomplish
past- all passive; a few weeks ago after sexual assault- made small cuts with an exacto knife, but this part was without SI intent; had them a long time ago in 9th grade (passive thoughts)

Section II: Self-Harm Screening

None (skip to next section) ○ None ◉ Self-mutilation

If "Self-mutilation" is selected, describe in detail; when, where on body, with what, required medical intervention? For how long, date of most recent.
last was almost a month ago, but says she doesn't do it anymore; on wrists with exacto knife; mostly superficial- only one was deeper; started in 9th grade and would do it every other night for a couple of months, then after would be periodically maybe 1x/month; says she stopped due to not liking to see the scabs on her wrists; cuts to either "get stuff out" or due to being numb

Section III: Aggression Screening

☐ **None (skip to next section)** ☐ **Verbal** ☑ **Physical**

Individual Risk Features (Describe in detail all factors specific to this individual that could place them at risk for self-harm (i.e., history of suicide attempts, family history of suicide, high risk behaviors with no regard to personal safety, etc.)
reports in 7th and 8th grade would fight- says a lot for a few months after her friend committed suicide, then reduced and there's been no physical aggression since then

Environmental Risk Features (Describe in detail all factors specific to the individual's environment that could place them at risk for self-harm (i.e., access to weapons, drugs/prescribed medications, lack of family/social supports, isolation, etc.)
Client seems to have some access to pain medications. She reports she only takes those as prescribed, but seems experimental with other drugs so it could be a potential concern.

Section IV: Risk Category

Risk Category (See Key): ○ No safety risk ◉ Mild safety risk ○ Moderate safety risk ○ High safety risk

Key:
NO SAFETY RISK:
1. Routine Monitoring; 2. No thoughts; 3. No plan; 4. No notification; 5. Safety environment

MILD SAFETY RISK:
1. Routine monitoring; 2. Discuss mild risk status with clinical team; 3. Some thought; 4. No plan; 5. Notify therapist

MODERATE SAFETY RISK:
1. Implement increased supervision; 2. Discuss moderate risk status with clinical team; 3. Some thought; 4. No plan; 5. Notify therapist; 6. Develop Personal Safety Plan (add to Tx Plan)

HIGH SAFETY RISK:
1. Line of sight supervision (use LOS doc. sheet); 2. Psychiatric consult; 3. Re-evaluation of risk at each session; 4. Develop Personal Safety Plan (add to Tx Plan)

Family History

Mother's Name: Perry Hatch **Age:** maybe 50's?

Father's Name: Paul Hatch **Age:** 57

Step-parents or surrogate? ○ No ◉ Yes

If yes, complete questions below where applicable:

Name: Donna **Relationship:** biological mother (since birth) **Age:**

Name: **Relationship:** **Age:**

Name: **Relationship:** **Age:**

Name of Sibling(s) / Step Siblings and Age?
biological siblings (says she has no contact with them) - older sister Angel (17 or 18 yo), older brother Christopher (20yo), other older brother (20yo); older brother Eddie (22yo)
adopted family- older sister Jett (20yo) that was also adopted

Is there any current or past family history of substance related disorders and/or psychiatric illness? ○ No ◉ Yes

If Yes, please describe:
adoptive grandfather was an alcoholic

Is there any current or past family history of medical issues (diabetes, etc)? ○ No ◉ Yes

If Yes, please describe:
Adoptive mom has pre-diabetes

Raised by: ○ Parents ○ One Parent ○ Relatives ○ Foster ◉ Adoptive

Describe your childhood:
Says it was "fine and she was happy" (had minimal response and needed some prompting to answer)

As a child, did you feel that all your physical and emotional needs were met by your parents or caregivers?
○ No ◉ Yes

Describe your past and current relationships with parents/siblings/others (important bonds, strained relationships, losses, etc):
adoptive mother- very strained and conflicted for the past 3 years; says things are fine with Dad and says sister is her best friend

can't have any contact with bio- mom until 18yo, and at this time unsure if she wants to or not

List or describe how your substance abuse or another family member's substance abuse has affected your family:
says parents don't really know that she drinks or smokes or says it doesn't affect them

Residence: ○ Own ○ Rent ◉ Living w/family ○ Living w/friends ○ Group/Boarding Home ○ Shelter ○ No stable residence ○ Homeless

Lives with? parents

Is your current living environment safe? ○ No ◉ Yes

What has been your usual living arrangement for the past three years?
lived with parents (moved 2x- house to an apartment, then an apartment to a house) moved to be closer to her school

Were you or any other family member emotionally, physically or sexually abused? ○ No ◉ Yes

If Yes, please list the relationship of the abused, abuser and type of abuse:
reports that Mom (Perry) was raped when younger and her father (client's maternal grandfather) was an alcoholic; sexual assault of client few weeks (didn't want to give any other details, but says mom and dad know and that it was reported to the police, says she got medical care)

Would you like counseling for these issues? ◉ No ○ Yes

Are you experiencing any family problems? ○ No ◉ Yes

If Yes, please explain:
conflict with Mom

Are you interested in counseling for family problems? ◉ No ○ Yes

Is your living environment supportive? ○ No ◉ Yes

Explain:

Can you return there or do you need placement? ◉ Return Home ○ Need Placement ○ Uncertain

Explain as needed:

Will your family or significant other participate in your treatment? ○ No ◉ Yes

Explain
will come out for some of the weekends and will do video therapy sessions with them (client doesn't want it, but knows it's part of this treatment)

What is your family / significant other's expectation of your treatment?
expecting everything to be fine; mom thinks things are my fault; dad thinks things are my partly my mom's fault

Interview with family / significant other (if applicable):
see parent intake

With whom do you spend most of your free time and how?
with my best friend Paulina; watch movies in my basement and eat chocolate muffins

Do you have a recovery support network in place? ○ No ◉ Yes

Please describe:
multiple friends, parents, sister

Are you experiencing any social problems? ◉ No ○ Yes

Are you interested in counseling for social problems? ◉ No ○ Yes

Relationship / Marital History

Has any relationship dissolved due to alcohol/drug/mental health problems? ◉ No ○ Yes

If currently married or in a relationship, name and age of partner:

Is partner living with you? ◉ No ○ Yes

Are you satisfied with your current relationship? ○ No ○ Yes

Other than client, does anyone in the home abuse alcohol/drugs? ◉ No ○ Yes

Are you experiencing or have you experienced any domestic violence issues? ◉ No ○ Yes

School/Education

What was the highest grade you completed? 9th **GED:** ◉ No ○ Yes ○ N/A

If you did not graduate, explain why? still in school

Training or technical education completed? no

Are you interested in furthering your education? ○ No ◉ Yes

Any behavioral issues, learning barriers (such as disabilities, illiteracy), physical limitations (such as vision/hearing) or traumatic experiences that are significant to educational history? ○ No ◉ Yes

If Yes, please explain:
ADHD and wearing glasses; says she had a bad concussion (from dance and hitting head on pole during a leap) in 8th grade that really delayed learning and still can get headaches that last for 8 days

Are you aware of having had any developmental delays age 0-5 years (speech, walking, toileting, socializing, reading)? ◉ No ○ Yes

List or describe any substance abuse history that created problems and / or consequences that occurred during school years:
none reported

Cultural / Spiritual History

Spiritual beliefs, upbringing and values within family of origin and how it affected you:
was baptized Catholic; grew up Christian (used to go to church a lot)- doesn't think it affected her (says she still ended up doing drugs either way0

Do you have a spiritual belief, or a higher power? ○ No ◉ Yes

Explain
Christian- but says she doesn't care that much anymore

Are your beliefs and spiritual practices a significant part of your life? ◉ No ○ Yes

Do you attend formal religious / spiritual practice? ◉ No ○ Yes

Do you meditate or pray regularly? ○ No ◉ Yes

How has your substance abuse affected your spiritual aspect of life?
not at all "If Jesus could drink all the time, then so could I."

Do you feel your spiritual belief/higher power will have an impact on your recovery? ◉ No ○ Yes

History of cultural influences:
none reported

Are there any cultural, racial or ethnic background issues that will impact your recovery? ◉ No ○ Yes

What is your cultural attitude toward substance abuse?
"never really thought about it"

Sexual History / Orientation

Describe your current sexual orientation:
heterosexual

Have you always had the same sexual orientation: ○ No ◉ Yes

Age you became sexually active: 15

Was your participation consensual? ○ No ◉ Yes

Explain:
with boyfriend; did other sexual acts other than intercourse prior to that

If Yes, explain:
didn't want to say much other than that she has had "random,meaningless sex

Have you had multiple sexual partners? ○ No ◉ Yes

If Yes, explain:
says it would be just random and had no other answer for it; recently thought she was pregnant, but says no after taking multiple tests both on own and at the Doctor's

Have you ever engaged in unprotected sex? ○ No ◉ Yes

Have you ever experienced gender identity issues? ◉ No ○ Yes

Have you ever experienced Sexual Compulsivity / Addiction? ◉ No ○ Yes

Are you experiencing any guilt or shame regarding your sexual orientation and/or sexual practices? ◉ No ○ Yes

Recreation

Describe what type of recreation activities you have enjoyed:
dance, cheer, gymnastics, softball, track, swimming, golf

During the past year, how often have you participated in these activities:
cheer- not that much and dance not really since surgery; says the others not really at all

Has the frequency of these activities been affected by your relationship with substances? ◉ No ○ Yes

Describe what type of recreation activities you would like to learn or start to engage in:
being out in the sun (she already does that and didn't want to identify anything new)

Employment History

Currently employed? ◉ No ○ Yes

If No, how long unemployed and how do you support yourself?
had a job last summer and giving spray tan; parents help support

Previous job history (types of jobs held, where, when and reason for leaving):
babysitting and giving spray tans (stopped due to moving and being in school)

Ever had problems at work related to Mental Health: ◉ No ○ Yes

Has anyone at work expressed concern about your Mental Health? ◉ No ○ Yes

Does your employer require notification of your treatment? ◉ No ○ Yes

Does someone contribute to your financial support? ○ No ◉ Yes

If Yes, explain:
parents

Do people depend on you for basic needs (food, shelter, etc.)? ◉ No ○ Yes

Vocational interests and goals:
neurosurgeon

Would employment counseling be of interest to you now? ◉ No ○ Yes

Legal History

Have you ever been arrested? (•) No ( ) Yes

Pending charges? (•) No ( ) Yes

Upcoming court dates? (•) No ( ) Yes

Have any of your charges resulted in convictions? (•) No ( ) Yes

Have you ever been incarcerated? (•) No ( ) Yes

Are you currently on probation or parole? (•) No ( ) Yes

Required to register under Megan's Law? (•) No ( ) Yes

Explain:

Would counseling for legal issues be of interest to you now? (•) No ( ) Yes

Mental Status Summary

Interviewing Counselors Interpretations

General Observations:

☐ neat	☐ dirty	☐ appears younger	☐ messy
☑ clean	☐ unkempt	☑ appears older	

Physical Attire:

☐ appropriate	☐ inappropriate	☐ well groomed	☑ flashy

General Manner:

☐ reserved	☐ shy	☐ tense	☐ suspicious
☐ apathetic	☐ embarrassed	☐ distant	☐ defiant
☐ resentful	☐ candid	☐ submissive	☐ high strung
☑ fragile	☐ grandiose	☐ monotone	☐ serious
☐ defensive	☐ irritable	☐ courteous	☐ cooperative
☑ indifferent	☐ perceptive	☐ hostile	

Thought Process:

☐ appropriate	☐ manipulative	☐ irrelevant	☑ vague
☐ calculating	☑ elusive	☐ indirect	☐ flight of ideas
☑ distractible	☐ spontaneous	☐ expressionless	☐ circumstantial
☐ disconnected	☐ mute	☐ tangential	☐ overly inclusive
☐ confronting	☐ sarcastic	☐ slow	☑ emotionless

Emotional Reactions:

☐ spontaneous	☐ apprehensive	☐ elated	☐ perplexed
☑ superficial	☐ dissatisfied	☐ depressed	☐ angry
☐ confused	☑ indifferent	☐ fearful	☑ anxious
☐ euphoric	☐ apathetic	☐ tearful	

Speech:

☐ flat	☑ appropriate	☐ rambling
☐ pressured	☐ slurred	

Affect:

☑ appropriate	☐ shallow	☐ incongruent	☐ blunt
☐ flat			

Orientation:

☑ time	☑ person	☑ place	☑ situation

Hallucinations:

Hallucinations ○ No ○ Yes

If YES, check types:

☐ auditory	☐ visual	☐ olfactory	☐ tactile

If Yes, describe content, frequency and duration:

Delusions

Delusions ○ No ○ Yes

If Yes, check types: ☐ themes ☐ grandiose ☐ persecutory

Evaluative Summary

Motivation level is: ○ Precontemplation ◉ Contemplation ○ Preparation ○ Action ○ Maintenance ○ Relapse

After meeting and reviewing medical, substance abuse, mental health and social history, client challenges (i.e., overuse of defense mechanisms, distrust, cognitive limitations, etc.) during treatment may include:
Client minimizes substance use and sexualized behaviors. She is distrusting of others and appears to have attachment based issues, especially with maternal figures. She struggles with emotional and physical boundaries which may affect her interactions in RTC.

After meeting and reviewing medical, substance abuse, psychiatric and social history, client is likely to excel in the following areas during their treatment stay:
Experiential based therapies, sports related activities, engaging with peers

What approach (or combination of services) will most likely yield the most effective treatment outcome for this client?
DBT, CBT, maybe mentalization for attachment, family systems work

Interpretive Summary

Client Composite (describe the central themes that will need to be addressed during the client's treatment, including the client's psychological assessment and any co-occurring disorders or disabilities):

Client will address her symptoms of anxiety and depression, as well as the underlying causes to each. Client will explore how her reported traumas and losses impact both anxiety and depressed mood, as well as how it influences her emotional dysregulation. Client has a lot of feelings of blame toward adoptive mom for "taking her away" from bio-mom, so addressing feelings being projected and displaced will be beneficial for client. Client seems to struggle with self-identity and feeling validated, which can be addressed through using mindfulness, interpersonal skills, and learning emotional regulation and distress toleracne. Client's family dynamics other than attachment/adoption will also need to be addressed as their seems to be a lot of conflict reported and poor communication patterns.

Presenting Illness and Underlying Problems:
Anxiety- naseous, worrying about everything (the future, all the things that could happen, if natural disasters are going to happen, etc), restless, some panic, rumination, tense, possible flashbacks (but denied most other truama sx)
Depression - low self-worth, trouble concentrating, low appetite, can't sleep at night but wants to sleep during the day, poor sense of self, feels sad/empty/depressed, loss of interest in pleasurable activities, no motivation, hopelessness, hx of SI, hx of self-harm (says this mostly started after her surgery in Jan. 2018 and all but SI are experienced daily
ADHD- poor historian, easily distracted, loses train of thought, impulsive, restless, loses things easily, has a lot of energy, both at school and home since she was young
BPD traits
Substance abuse/use - nicotine and alcohol mostly, others include marijuana and experimenting with other drugs
Disordered eating issues- client reports she will eat small amounts, then forces herself to excessively exercise until hitting a target weight of 98lbs. (thx followed up with Mom who contradicted this saying client has had a healthy appetite, not worked out that often, and for a while been consistently weighing at 110-11lbs so this may need further assessment and observation)

Recommended Program/Level of Care:
residential

Client Strengths, Needs, Abilities and Preferences (Clinician's impressions):
Client appears socially adaptable, friendly, athletic, and seeking support from others. She needs structure, guidance, validation, support in strengthening self-efficacy, and stability. She is in need of relationships modeling healthy boundaries and building her sense of self She lacks insight to the impact of her behaviors and how she responds to her emotional triggers. Given the appropriate psychoeducation and tools, client should be able to increase insight and judgment. Client is open-minded about the different treatment option.

Client Needs that will be Addressed in Treatment:
depression, anxiety, reported trauma, family issues, unhealthy relationships due to low self-value and poor boundaries, substance use, attachment issues from adoption

Client Needs that will NOT be Addressed in Treatment:
none at this time

Support System:
parents, sister, and client reports a good group of supportive friends at home

Clinical Impressions:
Client is a 16 year old female that is entering treatment willingly. Client reports she has always struggled with anxiety and ADHD sx/bx (impulsivity, hyperactivity, easily distracted), and that since her back surgery in Jan. 2018, which led to her not being able to dance competitively anymore, she has been struggling with depression. She reports a history of passive SI without plans, as well as a hx of self-harm (superficial cutting on wrists) with the most recent incident being a few weeks ago. Client reports having a lot of conflict with her mother, and that she blames her for "taking her away" (adopting) her from her bio-mom (client says mom does not know this). Client struggles with healthy boundaries, both physically and emotionally, but seems to lack insight to this so she would benefit from modeling of appropriate boundaries and guidance within groups and with staff. Client displays some attachment issues and indicates a fear of abandonment and rejection, as well as highly sexualized behaviors. These symptoms indicate Borderline traits and more assessment is needed to make a full diagnosis. Client has reported a sexual assault that occurred a few weeks ago, which parents confirmed was reported to the police. There were some gaps in the report between what client shared and what parents said, so this will need to be further explored with client. Client reports a poor appetite and that when she does eat, it's often small amounts and then she exercises excessively to maintain a low weight. This was not confirmed by parents and they stated there's been no change in client's appetite and she's been at a consistently healthy weight, so more assessment and observation is needed in order to rule out specific eating disorder issues. Client denies using any marijuana for the past few months, but prior to that was using frequently. Has abused alcohol (denies any in the past 2-3 weeks) and vapes nicotine. Further assessment is also needed in order to rule out PTSD and RAD.

Diagnosis

Code System	Code	Description

DSM5	296.33 (F33.2)	F33.2 Major depressive disorder, Recurrent episode, Severe
DSM5	300.02 (F41.1)	F41.1 Generalized anxiety disorder
DSM5	314.01 (F90.2)	F90.2 Attention-deficit/hyperactivity disorder, Combined presentation
DSM5	301.83 (F60.3)	Borderline personality traits

Contact Signatures

Treatment Team Signatures

--Digitally Signed: 10/02/2018 07:58 am Program Director, Licensed Professional Clinical Counselor Emily Armour
--Digitally Signed: 10/02/2018 10:01 pm Counselor Tracy Bangar
--Digitally Signed: 10/03/2018 02:54 pm Lead Therapist, LMFT Matthew Porter
--Digitally Signed: 10/04/2018 07:10 pm Therapist Daniela Sandelin
--Digitally Signed: 10/05/2018 12:55 pm Counselor Oliver Drakeford

Master Treatment Plan

Demographics

Client Name:	Campbell Hatch	**Date:**	10/04/2018
		Time:	
Provider:	Tracy Bangar	**Date of Original MTP:**	10/04/2018
MR#:	10167	**Admit Date:**	09/30/2018
Date of Birth:	04/19/2002		
Age:	16	**Length of Stay:**	

Diagnosis

Code System	Code	Description
DSM5	296.33 (F33.2)	F33.2 Major depressive disorder, Recurrent episode, Severe
DSM5	300.02 (F41.1)	F41.1 Generalized anxiety disorder
DSM5	314.01 (F90.2)	F90.2 Attention-deficit/hyperactivity disorder, Combined presentation
DSM5	301.83 (F60.3)	Borderline personality traits

Explanation of Changes to Diagnosis

none at this time. Still need further assessment and observation to rule out ED, PTSD, and RAD.

Reason for Admission

depression, anxiety, ADHD sx/bx, family conflict and attachment issues, impulsive and self-destructive behaviors

Master Problem List

Date	#	Problem	Active	EST Completed	Date Resolved
10/04/2018	1	Major Depressive Disorder	☑	10/29/2018	
10/04/2018	2	Generalized Anxiety Disorder	☑	10/29/2018	
10/04/2018	3	Attention-Deficit/Hyperactivity Disorder	☑	10/29/2018	
10/04/2018	4	Borderline Personality Disorder	☑	10/29/2018	

Strengths and Weaknesses

Strengths	drawing; singing; dancing (had to stop with spine surgery)
Needs	support (check-ins from staff), patience, honesty about what areas I can work on
Abilities	flexible (physically); cheer; archery, swimming; surfing
Preferences	individual tx; doesn't like family work, but knows that it is a component of the treatment here

Medication

Psychotropic Medications

Type	Status	PS	Medication	Indication	Dosage (Qty/Form)	Frequency
Rx	*Active*	PS	**Amphetamine Salts ER 25mg**		(1) 25mg (tablet)	mornings
			Med Notes: Option to take (2) 10mg IR tablets instead. DO NOT GIVE			
			10/1/2018: Medication Added			
	Active	PS	**Amphetamine Salts IR 10mg**		(2) 10mg tabs	every 4 hrs - as needed
			Med Notes: DO NOT GIVE IF 25MG cap was given			
			10/1/2018: Medication Added			

		Active	PS	**Sertraline(ZOLOFT) 200mg total**	MDD and GAD, PTSD	(2) 100mg tabs (tablet)	at bedtime
				10/1/2018: Medication Added			

Other Medications	Type	Status	PS	Medication	Indication	Dosage (Qty/Form)	Frequency
	Rx	*Active*		**Flonase inhaler**	Seasonal allergies	(1) spray in each nostril	once a day - as needed
				10/2/2018: Medication Added			
		Active		**Albuterol inhaler**	SOB/wheezing/asthma	(2) puffs (inhalations)	- as needed
				10/2/2018: Medication Added			
		Active		**Fish oli**		(1) cap (capsule)	twice daily
				10/2/2018: Medication Added			
		Active		**Raw Calcium**		(2) caps AM/ (2)caps PM (capsule)	twice daily
				10/1/2018: Medication Added			
		Active		**Magnesium Citrate 400mg**		(2) caps (capsule)	at bedtime
				10/1/2018: Medication Added			
	OTC	*Active*		**Ibuprofen**	PRN migraine/Headache/pain/fever	600mg (tablet)	every 8 hrs - as needed
				Med Notes: Twice a day max RECORD TIME GIVEN			
				10/2/2018: Medication Added			
		Active		**Melatonin 3mg total**	sleep onset insomnia	(1) 3mg tab (tablet)	at bedtime
				10/2/2018: Medication Added			
	Rx	*Active*		**Lo Loestrin Fe 1-10**	Contraception	(1) tab (tablet)	mornings
				10/1/2018: Medication Added			
	OTC	*Active*		**Tylenol (Acetaminophen)**	Migraine/headache/pain	500mg mg (tablet)	twice daily - as needed
				Med Notes: Record time given			
				10/2/2018: Medication Added			
Explanation of Changes							

Discharge Planning

Anticipated Discharge 10/29/2018

Date	
Living Arrangements	home with parents
Education	may be able to return to previous school with recommendation from treatment team
Therapy (Specify individual, family or group treatment)	individual, group, and family tx
Discharge Transition Obstacles	poor insight and judgment, anger/resentment towards mom

Resident Section

☑ I am involved in my care, including the development of my Master Treatment Plan.
☑ I am able to make recommendations about my care, my Master Treatment Plan and services provided for me.
☑ I have been able to express my views and make choices about my plan for care, treatment and services.
☑ I feel that the interventions involved in my Master Treatment Plan consider and respect my views.
☑ Conclusions of the assessments and recommendations for treatment, care, and services have been reviewed with me.
Comments
Resident Signature

Family Section

☑ The family/guardian is involved in developing the plan of care including the Master Treatment Plan.	
☑ The plan of care, the Master Treatment Plan as well as other services provided reflect the participation of the family/guardian.	
Family Goals (in family words)	We want her to be honest and be able to tell the truth. It is hard to know what is accurate and we want honest communication and understanding of natural consequences of not telling the truth. We want her to talk things out with us when discussing moral or life lessons.
Comments	
☑ Phone Consent	
Signature	

Contact Signatures

Treatment Team Signatures

--Digitally Signed: 10/04/2018 10:57 pm	Therapist Daniela Sandelin
--Digitally Signed: 10/05/2018 12:55 pm	Counselor Oliver Drakeford
--Digitally Signed: 10/08/2018 09:25 am	Program Director, Licensed Professional Clinical Counselor Emily Armour
--Digitally Signed: 01/27/2019 01:12 pm	Lead Therapist, LMFT Matthew Porter

Master Treatment Plan

Name: Campbell Hatch		MR#: 10167
Problem #	**Descriptor**	**As Evidenced By**
1	Major Depressive Disorder	Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation). Insomnia or hypersomnia nearly every day. Fatigue or loss of energy nearly every day. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick). Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

Goal #	Long Term/Discharge/Graduation Goals
1	Campbell will report a significant improvement in mood and sense of well-being.

Objective 1	**Date Created:** 10/04/2018	**Est. Completed:** 10/22/2018	**Resolved:**
Short-Term Objective:	Articulate the relationship between cognition and emotion as it relates to depressed mood by 10/22/18, and cite 3-5 personal example(s) of how thought processes effect mood.		
Interventions:	Activity for Daily Living (ADL) 2-4 time(s) per day. Family Therapy (Face-to-face) 1 time(s) per week. Family Therapy (Telephonic) 1 times per week. Group Therapy 3-4 time(s) per week. Individual Therapy 1 time(s) per day. Neurofeedback(NFT) minimum of 1 session, up to 2 sessions per week as agreed upon with treatment team		
Staff Created:	Tracy Bangar, Counselor	Staff Responsible: Tracy Bangar	
Reviewed/Updated:			

Goals: ☑ 1

Objective 2	**Date Created:** 10/04/2018	**Est. Completed:** 10/24/2018	**Resolved:**
Short-Term Objective:	Make 3-5 feeling statements in each individual therapy session over a period of 2-3 week(s).		
Interventions:	Activity for Daily Living (ADL) 2-4 time(s) per day. Family Therapy (Face-to-face) 1 time(s) per week. Family Therapy (Telephonic) 1 times per week. Group Therapy 3-4 time(s) per week. Individual Therapy 1 time(s) per day. Neurofeedback(NFT) minimum of 1 session, up to 2 sessions per week as agreed upon with treatment team		
Staff Created:	Tracy Bangar, Counselor	Staff Responsible: Tracy Bangar	
Reviewed/Updated:			

Goals: ☑ 1

Objective 3	**Date Created:** 10/04/2018	**Est. Completed:** 10/22/2018	**Resolved:**
Short-Term Objective:	Develop 2-3 strategies for each thinking error by 10/22/18.		
Interventions:	Activity for Daily Living (ADL) 2-4 time(s) per day. Family Therapy (Face-to-face) 1 time(s) per week. Family Therapy (Telephonic) 1 times per week. Group Therapy 3-4 time(s) per week. Individual Therapy 1 time(s) per day. Neurofeedback(NFT) minimum of 1 session, up to 2 sessions per week as agreed upon with treatment team		
Staff Created:	Tracy Bangar, Counselor	Staff Responsible: Tracy Bangar	

Reviewed/Updated:

Goals: ☑ 1

Master Treatment Plan

Name: Campbell Hatch		MR#: 10167
Problem #	**Descriptor**	**As Evidenced By**
2	Generalized Anxiety Disorder	Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance). The individual finds it difficult to control the worry. Restlessness or feeling keyed up or on edge. Being easily fatigued. Irritability. Muscle tension. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep). Difficulty concentrating or mind going blank.

Goal #	Long Term/Discharge/Graduation Goals
1	Campbell will achieve a significant reduction in symptoms of Anxiety.
2	Campbell will acquire relaxation/coping skills to effectively management stress/anxiety.

Objective 1	**Date Created:** 10/04/2018	**Est. Completed:** 10/22/2018	**Resolved:**
Short-Term Objective:	Campbell will Identify 3-5 contributing factor(s)/issue(s) that are responsible for feeling of anxiety by 10/22/18		
Interventions:	Activity for Daily Living (ADL) 2-4 time(s) per day. Family Therapy (Face-to-face) 1 time(s) per week. Family Therapy (Telephonic) 1 times per week. Group Therapy 3-4 time(s) per week. Individual Therapy 1 time(s) per day. Neurofeedback(NFT) minimum of 1 session, up to 2 sessions per week as agreed upon with treatment team		
Staff Created:	Tracy Bangar, Counselor	Staff Responsible: Tracy Bangar	
Reviewed/Updated:			

Goals: ☑ 1 ☑ 2

Objective 2	**Date Created:** 10/04/2018	**Est. Completed:** 10/29/2018	**Resolved:**
Short-Term Objective:	With the aid of caregiver, Campbell will acquire self-relaxation skills and implements them over a time period of 3-4 week(s) whenever restlessness sets in.		
Interventions:	Activity for Daily Living (ADL) 2-4 time(s) per day. Family Therapy (Face-to-face) 1 time(s) per week. Family Therapy (Telephonic) 1 times per week. Group Therapy 3-4 time(s) per week. Individual Therapy 1 time(s) per day. Neurofeedback(NFT) minimum of 1 session, up to 2 sessions per week as agreed upon with treatment team		
Staff Created:	Tracy Bangar, Counselor	Staff Responsible: Tracy Bangar	
Reviewed/Updated:			

Goals: ☑ 1 ☑ 2

Master Treatment Plan

Name: Campbell Hatch		MR#: 10167
Problem #	**Descriptor**	**As Evidenced By**
3	Attention-Deficit/Hyperactivity Disorder	Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading). Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction). Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked). Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines). Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers). Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones). Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts). Often fidgets with or taps hands or feet or squirms in seat. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place). Often unable to play or engage in leisure activities quietly. Often talks excessively. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation). Often has difficulty waiting his or her turn (e.g., while waiting in line). Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

Goal #	Long Term/Discharge/Graduation Goals
1	Campbell will be able achieve a significant increase in compensatory skills for the management of ADHD symptoms.

Objective 1	**Date Created:** 10/04/2018	**Est. Completed:** 10/29/2018	**Resolved:**
Short-Term Objective:	Will respond in a pro-social way when confronted by staff and peers regarding behavior characterized as being overly touchy, overly expressive, or easily annoyed with others over a 3-4 week time period.		
Interventions:	Activity for Daily Living (ADL) 2-4 time(s) per day. Family Therapy (Face-to-face) 1 time(s) per week. Family Therapy (Telephonic) 1 times per week. Group Therapy 3-4 time(s) per week. Individual Therapy 1 time(s) per day. Neurofeedback(NFT) minimum of 1 session, up to 2 sessions per week as agreed upon with treatment team		
Staff Created:	Tracy Bangar, Counselor	Staff Responsible: Tracy Bangar	
Reviewed/Updated:			

Goals: ☑ 1

Objective 2	**Date Created:** 10/04/2018	**Est. Completed:** 10/29/2018	**Resolved:**

Short-Term Objective:	Able to respond positively 50 % of the time with verbal/non-verbal behavior when prompted for inattentiveness by caregiver (therapeutic staff, educational staff) over a time period of 10/22/18 week(s).	
Interventions:	Activity for Daily Living (ADL) 2-4 time(s) per day. Family Therapy (Face-to-face) 1 time(s) per week. Family Therapy (Telephonic) 1 times per week. Group Therapy 3-4 time(s) per week. Individual Therapy 1 time(s) per day. Neurofeedback(NFT) minimum of 1 session, up to 2 sessions per week as agreed upon with treatment team	
Staff Created:	Tracy Bangar, Counselor	Staff Responsible: Tracy Bangar
Reviewed/Updated:		

Goals: ☑ 1

Objective 3	**Date Created:** 10/04/2018	**Est. Completed:** 10/29/2018	**Resolved:**
Short-Term Objective:	With the aid of the caregiver, Campbell will develop 2-3 strategies of avoiding stress triggers over a 3-4 week time period.		
Interventions:	Activity for Daily Living (ADL) 2-4 time(s) per day. Family Therapy (Face-to-face) 1 time(s) per week. Family Therapy (Telephonic) 1 times per week. Group Therapy 3-4 time(s) per week. Individual Therapy 1 time(s) per day. Neurofeedback(NFT) minimum of 1 session, up to 2 sessions per week as agreed upon with treatment team		
Staff Created:	Tracy Bangar, Counselor	Staff Responsible: Tracy Bangar	
Reviewed/Updated:			

Goals: ☑ 1

Master Treatment Plan

Name: Campbell Hatch		MR#: 10167
Problem #	**Descriptor**	**As Evidenced By**
4	Borderline Personality Disorder	

Goal #	Long Term/Discharge/Graduation Goals
1	Campbell will acquire a more measured and realistic sense of self and application of others.
2	Campbell will acquire skills to more effectively modulate emotion and relationships and thus arrive at an improved self-image.

Objective 1	**Date Created:** 10/04/2018	**Est. Completed:** 10/29/2018	**Resolved:**
Short-Term Objective:	Campbell will learn at least 3-5 elements that are critical in developing relationships and practice those concepts to family members, peers or staff.		
Interventions:	Activity for Daily Living (ADL) 2-4 time(s) per day. Family Therapy (Face-to-face) 1 time(s) per week. Family Therapy (Telephonic) 1 times per week. Group Therapy 3-4 time(s) per week. Individual Therapy 1 time(s) per day. Neurofeedback(NFT) minimum of 1 session, up to 2 sessions per week as agreed upon with treatment team		
Staff Created:	Tracy Bangar, Counselor	Staff Responsible: Tracy Bangar	
Reviewed/Updated:			

Goals: ☑ 1 ☑ 2

Objective 2	**Date Created:** 10/04/2018	**Est. Completed:** 10/29/2018	**Resolved:**
Short-Term Objective:	Campbell will discuss ways in which Campbell's behavior has impacted others and develop a list of at least 2-3 amends Campbell will begin to make to others as supported/observed by staff.		
Interventions:	Activity for Daily Living (ADL) 2-4 time(s) per day. Family Therapy (Face-to-face) 1 time(s) per week. Family Therapy (Telephonic) 1 times per week. Group Therapy 3-4 time(s) per week. Individual Therapy 1 time(s) per day. Neurofeedback(NFT) minimum of 1 session, up to 2 sessions per week as agreed upon with treatment team		
Staff Created:	Tracy Bangar, Counselor	Staff Responsible: Tracy Bangar	
Reviewed/Updated:			

Goals: ☑ 1 ☑ 2

Objective 3	**Date Created:** 10/04/2018	**Est. Completed:** 10/29/2018	**Resolved:**
Short-Term Objective:	Campbell will identify at least 2-3 "trigger(s)" that are associated with Campbell's impulsivity. Campbell will develop "challenges" or responses to each trigger and present them to staff, family, and peers for feedback.		
Interventions:	Activity for Daily Living (ADL) 2-4 time(s) per day. Family Therapy (Face-to-face) 1 time(s) per week. Family Therapy (Telephonic) 1 times per week. Group Therapy 3-4 time(s) per week. Individual Therapy 1 time(s) per day. Neurofeedback(NFT) minimum of 1 session, up to 2 sessions per week as agreed upon with treatment team		
Staff Created:	Tracy Bangar, Counselor	Staff Responsible: Tracy Bangar	
Reviewed/Updated:			

Goals: ☑ 1 ☑ 2

Discharge Summary

Demographics

Client Name:	Campbell Hatch	**Date:**	11/13/2018
		Time:	11:00 AM
Provider:	Tracy Bangar	**Date of Original MTP:**	10/04/2018
MR#:	10167	**Admit Date:**	09/30/2018
Date of Birth:	04/19/2002	**Date of Discharge:**	11/13/2018
Age:	16	**Length of Stay:**	45 days

Reason for Admission

depression, anxiety, ADHD sx/bx, family conflict and attachment issues, impulsive and self-destructive behaviors

Preliminary Diagnosis

Code System	Code	Description
DSM5	F33.2	F33.2 Major depressive disorder, Recurrent episode, Severe
DSM5	F41.1	F41.1 Generalized anxiety disorder
DSM5	F90.2	F90.2 Attention-deficit/hyperactivity disorder, Combined presentation
DSM5	F60.3	Borderline personality traits

Discharge Diagnosis

Code System	Code	Description
DSM5	F33.2	F33.2 Major depressive disorder, Recurrent episode, Severe
DSM5	F41.1	F41.1 Generalized anxiety disorder
DSM5	F90.2	F90.2 Attention-deficit/hyperactivity disorder, Combined presentation
DSM5	F60.3	Borderline personality traits

Explanation of Changes to Diagnosis

Still need further assessment and observation to rule out ED, PTSD, and RAD, unspecified somatic disorder, factitious disorder

Master Problem List

Date	#	Problem	EST Completed	Date Resolved
10/04/2018	1	Major Depressive Disorder	11/13/2018	11/13/2018
10/04/2018	2	Generalized Anxiety Disorder	11/13/2018	11/13/2018
10/04/2018	3	Attention-Deficit/Hyperactivity Disorder	11/13/2018	11/13/2018
10/04/2018	4	Borderline Personality Traits	11/13/2018	11/13/2018

Summary of Progress

Problem #		Long Term/Discharge/Graduation Goals
1	Major Depressive Disorder	Campbell will report a significant improvement in mood and sense of well-being.;

Client presented with sx of low self-worth, trouble concentrating, low appetite, can't sleep at night but wants to sleep during the day, poor sense of self, feels sad/empty/depressed, loss of interest in pleasurable activities, no motivation, hopelessness, hx of SI, hx of self-harm. Over the course of treatment client gained insight to how some of her negative self-thoughts and feeling influenced her behaviors and depressed mood. Client also explored some of the triggers to her precipitating SI or self-harm. Client was able to use positive affirmations and engage in healthy, meaningful relationships with others to help build her self-worth and perception of self, which led to a gradual decrease in depressive symptoms. By the end of treatment, client reported elevated mood related to depression, feeling more confident in herself, and increased her ability to validate herself. Client is aware of how negative core beliefs impacted her feelings of self-worth and expectations of relationships, and then how this affected her mood and behaviors.

Problem #		Long Term/Discharge/Graduation Goals
2	Generalized Anxiety Disorder	Campbell will achieve a significant reduction in symptoms of Anxiety.; Campbell will acquire relaxation/coping skills to effectively management stress/anxiety.;

Client presented with anxiety sx of feeling nauseous when worrying, worrying about everything (the future, all the things that could happen, if natural disasters are going to happen, etc), restless, some panic, rumination, tense muscles, and difficulty verbalizing her feelings and needs. Client struggled with these symptoms and often would speak rapidly, avoid speaking to peers and staff, use noises, or fabricate stories about what was going on, as a means to alleviate the discomfort of her anxiety. Throughout her treatment, client was able to practice coping skills such as mindfulness and grounding techniques as a means to calm down her racing thoughts, deep breathing and utilizing journaling as a means to decrease ruminating thoughts. By the end of treatment, client was able to manage anxiety adequately, was open to speaking with staff and peers and appeared more confident and had a better sense of self to move forward with. Client needs continued work on self-monitoring behaviors when experiencing anxiety and slef-motivation to utilize learned skills without assistance from others.

Problem #		Long Term/Discharge/Graduation Goals
3	Attention-Deficit/Hyperactivity Disorder	Campbell will be able achieve a significant increase in compensatory skills for the management of ADHD symptoms.;

Cline presented with sx/bx of being a poor historian, easily distracted, losing train of thought, restlessness, losing things easily, hyperactivity, impulsivity, and poor social interactions. Client made progress in recognizing ways to try and stay focused during conversation and to remind her of completing important tasks. Client gained insight as to how her impulsiveness needs to be self-monitored when feeling anxious or trying to fit in with peers, as she doesn't always think her decisions through as to how it can negatively impact future events.

Problem #		Long Term/Discharge/Graduation Goals
4	Borderline Personality Traits	Campbell will acquire a more measured and realistic sense of self and application of others.; Campbell will acquire skills to more effectively modulate emotion and relationships and thus arrive at an improved self-image.;

Client presented to treatment presenting with intense fear of rejection and abandonment, would would lead to self-destructive (reported experimental substance use, self-harm, unhealthy realtionships) and self-sabotaging behaviors within her relationships. Client also struggles with lack of self-identity, desire to feel validated, and quickly changing emotions and moods. Client would often embellish or story tell, as a result of her perception of situations and relationships being distorted. Over the course of treatment client learned DBT skills and was able to learn how to apply some of these skills to take a step back in a situation and recognize if she was responding to what was actually occurring, or to a fear of something or assumption about what was going on. Client needs continued work in DBT, especially in a group setting to practice distress tolerance and interpersonal relationship skills.

Strengths and Weaknesses

Strengths	drawing; singing; dancing (had to stop with spine surgery)
Needs	support (check-ins from staff), patience, honesty about what areas I can work on
Abilities	flexible (physically); cheer; archery, swimming; surfing
Preferences	individual tx; doesn't like family work, but knows that it is a component of the treatment here

Medication

Psychotropic Medications

Type	Status	PS	Medication	Indication	Dosage (Qty/Form)	Frequency
Rx	*Active*	PS	**Amphetamine Salts ER (Adderall XR)25mg**	Inattention, ADHD	(1) 25mg (tablet)	mornings - as needed
			Med Notes: Option to take (2) 10mg IR tablets instead. DO NOT GIVE			
			10/1/2018: Medication Added			
	Active	PS	**Amphetamine Salts IR (Adderall IR)20mg total**	Inattention, ADHD	(2) 10mg tabs	mornings - as needed
			Med Notes: DO NOT GIVE IF 25MG cap was given			
			10/1/2018: Medication Added			
	Active	PS	**Sertraline(ZOLOFT) 200mg total**	MDD and GAD, PTSD	(2) 100mg tabs (tablet)	at bedtime
			10/1/2018: Medication Added			
	Active	PS	**SEROQUEL (Quetiapine) 25mg total**	mood stabilization, augmentation of SSRI	25mg total (tablet)	at bedtime
			10/18/2018: Medication Added			

Other Medications

Type	Status	PS	Medication	Indication	Dosage (Qty/Form)	Frequency
Rx	*Active*		**Flonase inhaler**	Seasonal allergies	(1) spray in each nostril	once a day - as needed
			10/2/2018: Medication Added			
	Active		**Raw Calcium**	Hypocalcemia	(2) caps AM/ (2)caps PM (capsule)	twice daily
			10/1/2018: Medication Added			
	Active		**Magnesium Citrate 400mg**	mineral supplement, relaxation mineral, improve sleep	(2) caps (capsule)	at bedtime
			10/1/2018: Medication Added			

OTC	*Active*	**Ibuprofen**	PRN migraine/Headache/pain/fever	600mg (tablet)	every 8 hrs - as needed
		Med Notes: Twice a day max RECORD TIME GIVEN			
		10/2/2018: Medication Added			
	Active	**Melatonin 3mg total**	sleep onset insomnia	(1) 3mg tab (tablet)	at bedtime
		10/2/2018: Medication Added			
Rx	*Active*	**Lo Loestrin Fe 1-10**	Contraception	(1) tab (tablet)	mornings
		10/1/2018: Medication Added			
OTC	*Active*	**Tylenol (Acetaminophen)**	Migraine/headache/pain	500mg mg (tablet)	twice daily - as needed
		Med Notes: Record time given			
		10/2/2018: Medication Added			
	Active	**ferrous sulfate (iron)**	iron deficiency anemia	65mg total	twice daily with food
		10/6/2018: Medication Added			
	Active	**vitamin C 1000mg total**	enhance iron absorption, better immune health	(1) 500mg	twice daily with iron
		10/6/2018: Medication Added			
Rx	*Active*	**Fish oli**	Cerebral health	(1) cap (capsule)	twice daily
		10/2/2018: Medication Added			
	Active	**Albuterol inhaler**	SOB/wheezing/asthma	(2) puffs (inhalations)	- as needed
		10/2/2018: Medication Added			
OTC	*Discontinued*	**prune juice**	Constipation	one cup	daily
		10/30/2018: Status Changed: Discontinued 10/9/2018: Medication Added			

Explanation of Changes

Discharge Planning

Anticipated Discharge Date	11/13/2018
Living Arrangements	home with parents
Education	may be able to return to previous school with recommendation from treatment team
Therapy (Specify individual, family or group treatment)	individual, group, and family tx
Discharge Transition Obstacles	poor insight and judgment, anger/resentment towards mom

Condition on Discharge

Client was anxious throughout morning and discharge process. She struggled somewhat with final agreement about her social media usage, but was receptive to intervention from staff and mother,then able to discharge successfully.

Reason for Discharge

Client completed 45 days of treatment and it was deemed clinically appropriate that client step down in treatment and attempt to work at a lower level of care, while still receiving support from group and individual therapy to assist with her transition back home and starting school next semester. Client has

gained significant coping skills for unsafe thoughts/behaviors, anxiety, and how to build healthy relationships. Client is motivated to continue mental health treatment when she goes back home and has a plan in place to seek support from her family and friends while attending a 6 week IOP.

Family/Guardian Participation in Treatment

Family participated well in client's treatment attending 8 family therapy sessions in totally. Family members attended in person often, most noticeably client's mother attending Family Day most weekends. Client's father participated less, and client's sister attended once. Client's mother was active in PET groups and was willing to engage in MFG.

Client's progress over treatment was erratic. Client made progress towards the end of treatment, however appeared to regress at times, and significantly in the final week of treatment. Client's decompensation was likely in part of evacuation of treatment center to temporary accommodation, and also some anxiety around returning home. However client's capacity for insight was reduced under these conditions so it remains uncertain if client could observe he progress or behaviors.

Client's initial levels of hostility and anger lowered over treatment and she began repairing relationship by taking responsibility for some of her behaviors and addressing adoption trauma that was potentially underneath some of her symptoms.

Client's mother was active in treatment and appeared to make solid progress on communication skills and containing her own anxiety. Client's father was less engaged in the process, reasons why were not explored due to time constraints.

If client continues DBT skills and insight-oriented therapy, while client's parents engage in their own treatment, prognosis is moderate to fair.

Critical Events & Interaction

10/7- during horseback riding, client witnessed another horse roll, and her somatic sx intensified (blindness, numbness, not being able to walk, extreme back pain, etc).

10.13 - client left family session abrubtly after becoming agitated. Later stated she had punched a wall in frustration and had evidence of grazing on her knuckles from impact.

10/18- Client reported SI 1x on 10/18/18 saying she was going to "cut her throat" and rated it a 5 out of 10. After speaking with therapist about her adoption and how it's impacted her life and her relationship with her parents, she reported feeling better and that her SI was gradually decreasing and that there was no plan, intent, or means. Client felt committed to keeping herself safe and by the end of the night no longer reported SI.

10/22 & 10/23- On the night of 10/22/18 and first half of the day on 10/23/18, client reported intense back pain and spasms that was preventing her from moving around easily and she was increasingly irritable and anxious. On 10/23/18, client laid down on the bathroom floor at the gym and claimed to need an ambulance due to the back pain. Eventually, she was able to get up and when she returned back to house isolated from group claiming her back hurt too badly to walk up the stairs. The night of the 22nd there was another peer that injured his ankle (this peer became highly anxious about it and kept stating he thought he needed the hospital). On the morning of the 23rd that peer with the ankle and another peer with wrist injury went to urgent care and came back with braces on them. This may led to client embellishing some of her sx after seeing peers getting attention due to physical injuries and due to her having heightened somatic sx when anxious. Client's mood improved and the pain reduced when the peer with the wrist injury stated they were feeling better and rejoined group. Therapist and client discussed her back pain and the possibility of it being more related to what she was feeling and due to seeing other peers that were also experiencing injuries/illnesses that day and previous night. Client was adamant that she had back pain, but once she became aware that she had isolated herself also, then she acknowledged that part of it could have been due to certain emotions she was experiencing.

10/29- client became upset with a peer and reportedly hit a wall- she had slightly red knuckles and iced them, then later in the evening reported they were feeling fine. Instead of talking about the peer she was upset with, client stated her anger was directed towards a girl at home that provided client's parents with a different story about client's reported assault the few weeks prior to arriving to RTC. Client was able to further talk about her frustrations and then calm, as well as recognize that she needs to continue working on ways to manage her anger and regulate her emotions.

Prognosis

If the client and her family follow recommendations provided by treatment team, the client's prognosis for achieving a successful recovery process, as well as a solid foundation for long term emotional health, is positive. If these recommendations are not followed, it is the belief of the treatment team that the client will

have difficulty achieving mental stability, emotional satisfaction, healthier familial dynamics, and could suffer significant personal and interpersonal consequences.

Recommendations

1.It is recommended that Campbell continue her treatment at a lower level of outpatient care by attending and IOP (with focus on DBT groups) and individual therapy in order to form relationships and interact with peers in order to gain necessary support that she needs around self-esteem, emotional regulation, transition's in one's life, and interpersonal skills. Client will also receive psychiatric services through this IO for continued evaluation and medication management..
The Clinical Recommendation is continued care:

Peachtree DBT- this is the one that has a DBT skills group for teens and parents/family that is on the same night. This would be beneficial so you could better understand some of the skills she will be learning/practicing to help apply it at home.
https://peachtreedbt.com/services/dbt-skills-classes

Ray of Hope Counseling Services- this has teen DBT skills groups for girls 13-17yo and has an office in Kennesaw
https://www.rhcounselingservices.com/adolescent-dbt-for-girls

Hillside Atlanta- this one seems like it allows you to put together a schedule of outpatient therapy programs (individual, groups, DBT groups, family)
https://hside.org/outpatient-therapy-at-hillside/

Peachford Hospital IOP- this one is a Intensive Outpatient program Monday-Friday 9am-12pm. I would recommend doing the 1x/week DBT skills group in addition to this.
https://peachford.com/programs/adolescents/adolescent-intensive-outpatient/

Ridgeview Institute- this one is an IOP (they have 2 locations and I believe the Smyrna program is closer to you than the Monroe location); you would need to call this one to ask about the schedule of the IOP. It doesn't seem focused on DBT, so I would still recommend the 1x/week DBT skills group with this.
https://ridgeviewinstitute.com/youth-program/

** Client's parents confirmed client will begin DBT IOP at Hillside that is 6 weeks (M-F 8am-4:30pm) on 11/26/18 and she will see former therapist Keely on the 11/17 and 11/24 prior to beginning IOP.

Family Therapist

Burton Maugans
https://www.psychologytoday.com/us/therapists/burton-t-maugans-kennesaw-ga/131674?sid=1540934040.7733_2771&city=Kennesaw&state=GA&spec=311&ref=5&tr=ResultsName

Chip Carter
https://www.psychologytoday.com/us/therapists/chip-carter-kennesaw-ga/258545?sid=1540934040.7733_2771&city=Kennesaw&state=GA&spec=311&ref=8&tr=ResultsName

Madison West: Marriage & Family Therapist, MA, LMFT 678-929-1175

Sarah B. Pyler: Marriage & Family Therapist, MS, LMFT, CFLE 678-712-2210

3. It is recommended that client be involved in some form of physical activity 2-3X per week and be involved in an extracurricular activity in order to interact with peers her age.
- client plans to fulfill this by getting back into cheer and dancing for a hobby

Contact Signatures

Treatment Team Signatures

–Digitally Signed: 11/20/2018 07:37 pm	Program Director, Licensed Professional Clinical Counselor Emily Armour
–Digitally Signed: 11/28/2018 12:39 pm	Counselor Oliver Drakeford
–Digitally Signed: 11/29/2018 10:39 pm	Counselor Tracy Bangar

Campbell Hatch
November 12, 2018 6:26pm

Paradigm Malibu
Chelsea Neumann, M.D.

Psychiatrist Note

Client Name: Campbell Hatch
Date of Session: 11/12/2018
Admission Date: 09/30/2018

Note:
Psychiatric Review

Interval history
Campbell seen today for final review before discharge. She is looking forward to returning home though endorses anxiety about this. Plans to engage in IOP and see her individual therapist and psychiatrist after. Endorses improvement in emotion regulation, depression and feels more aware of the destructive nature of her dishonesty which often distracts her from dealing with her emotional problems. Maintains she has been sexually assaulted and fixates on this as her main stressor. Is looking forward to returning home with her family and "move on with my life." Anticipatory guidance provided regarding return to home, school and social setting. Has been tolerating the evacuation due to fires well, but today had a headache and has been refusing to engage in treatment programming.

Tolerating medications (sertraline 200mg, Vyvanse 45mg and Seroquel 25mg) well, sleep has improved and she endorses improvement in mood lability, extreme anxiety and panic attacks since initiation of Seroquel. Would like to continue this medication.

MSE: 16 year old female, appearing better kempt, well groomed, good eye contact, psychomotor normal, sitting in a chair, calm and cooperative. Speech normal rate, rhythm and volume. Mood "better, more even" and affect congruent, constricted in range, appropriate, euthymic. TP linear, GD, and TC without current SI, HI, VI, no AVH, no delusions elicited, does not appear to respond to internal stimuli. Cognition grossly intact, I/J improving.

Labs completed 10/4/18:
iron, ferriting and MCHC low indication iron deficiency anemia.

Impression/Formulation
Campbell is a 16 year old adopted Caucasian female with history of scoliosis surgery and rod placement January 2018, chronic pain and somatic symptoms related to the surgery, recent alleged sexual assault and breakup from her boyfriend one month ago, and reported symptoms of an unspecified eating disorder, who presents for admission to RTC due to symptoms of a major depressive disorder, self-injury and suicidal ideation the past month, and symptoms of anxiety, PTSD and somatic symptoms that have been treatment resistant to outpatient therapy and medication management. Today, she endorsed SI and feeling overwhelmed and unable to understand her emotions and why she lies, but later engaged in discussion about how difficult it is to address her true feelings without hiding being stories she makes up about her life. Of note, Campbell's self-report of historical events and psychiatric symptoms appear to be inconsistent at times and this has been described as similar to what her parents have noticed as well. Campbell is at elevated risk for harm to herself, due to history of impulsive self-injury and past SI, symptoms of treatment-resistant depression, anxiety, and ADHD in addition to chronic pain and recent impulsive and oppositional behaviors, and limited insight into her condition, though protective factors include access to mental health care, motivation for care and engagement in treatment, and supportive parents. She can be appropriately managed at an RTC level of care. Plan for discharge to home with ongoing psychotherapy and IOP level of care.

Diagnoses
MDD, severe, recurrent, without psychotic features
GAD
ADHD, combined type
Somatic symptom disorder
Factitious disorder
Rule out PTSD, unspecified eating/feeding disorder, reactive attachment disorder, conversion disorder, BPD
BPD/HPD traits

Plan:
The client does not meet criteria for inpatient psychiatric admission or psychiatric hold at this time.

Clinical assessment is ongoing for diagnostic clarification.

Psychiatric Medications:
- Continue Seroquel 25mg po QHS for mood stabilization, augmentation of SSRI.
- Continue melatonin 3mg po QHS for sleep onset insomnia
- Continue Zoloft 200mg for MDD and GAD, PTSD
- Continue Vyvanse 25mg daily for inattention, ADHD
- Continue Adderall IR 20mg daily PRN inattention, ADHD if not taking XR.

Medical:
- Prune juice has been discontinued.
- For migraines, Ibuprofen 600mg BID PRN migraine, headache, pain, and Tylenol 650mg BID PRN migraine, headache, pain
- Albuterol inhaler 2 puffs twice PRN SOB, wheezing, for asthma to use when playing sports.
- Continue fish oil 1 capsule po BID
- Continue other current medications
- Gluten free diet
- Flonase nasal spray 1 spray each nostril daily PRN seasonal allergies
- Recommend probiotic supplementation but client declines.
- Recommend nutritional consultation, meal buddy to encourage appropriate caloric intake, monitoring closely for excessive exercise, calorie restricting and purging.
- Nutritional status significant for iron deficiency anemia, treated with iron supplementation and Vitamin C.

Plan for discharge tomorrow.
Recommend IOP level of care, ongoing individual and family therapy upon discharge.

Recommend engagement with healthy lifestyle learning including regular exercise, diet and mindfulness/meditation, in addition to other therapeutic resources available within the program, and in her community.

Psychiatrist Signature:
--Digitally Signed: 11/12/2018 06:32 pm Medical Director Chelsea Neumann, M.D.

ADHD, combined type
unspecified somatic symptom disorder
Rule out PTSD, unspecified eating/feeding disorder, reactive attachment disorder, conversion disorder, BPD
BPD traits

Plan:
The client does not meet criteria for inpatient psychiatric admission or psychiatric hold at this time.

Clinical assessment is ongoing for diagnostic clarification.

Psychiatric Medications:
- Continue melatonin 3mg po QHS for sleep onset insomnia
- Continue Zoloft 200mg for MDD and GAD, PTSD
- Continue Adderall XR 25mg daily PRN inattention, ADHD
- Continue Adderall IR 20mg daily PRN inattention, ADHD if not taking XR.

Medical:
- Start prune juice daily for constipation
- It was recommended to Campbell to inform staff when she is experiencing nausea and vomiting to record how often she is experiencing these symptoms and in which contexts.
- For migraines, Ibuprofen 600mg BID PRN migraine, headache, pain, and Tylenol 650mg BID PRN migraine, headache, pain
- Albuterol inhaler 2 puffs twice PRN SOB, wheezing, for asthma to use when playing sports.
- Continue fish oil 1 capsule po BID
- Continue other current medications
- Gluten free diet
- Flonase nasal spray 1 spray each nostril daily PRN seasonal allergies
- Recommend probiotic supplementation but client declines.
- Recommend nutritional consultation, meal buddy to encourage appropriate caloric intake, monitoring closely for excessive exercise, calorie restricting and purging.
- Nutritional status significant for iron deficiency anemia, and has been started on iron supplementation and Vitamin C.

Will maximize collateral with parents and outpatient clinicians.

Will plan to see weekly, sooner as needed for psychiatric assessment. Ongoing assessment needed for diagnostic clarification, treatment planning.

Recommend individual, group and family therapy. Recommend further exploration of grief symptoms.

Recommend engagement with healthy lifestyle learning including regular exercise, diet and mindfulness/meditation, in addition to other therapeutic resources available within the program.

Psychiatrist Signature:
--Digitally Signed: 10/09/2018 04:50 pm Medical Director Chelsea Neumann

Campbell Hatch
October 3, 2018 3:25pm

Paradigm Malibu
Chelsea Neumann, M.D.

Psychiatrist Note

Client Name: Campbell Hatch
Date of Session: 10/03/2018
Admission Date: 09/30/2018

Note:

Psychiatric review

Interval history
Campbell seen today, endorses ongoing anxiety, feeling nauseated and requesting Zofran due to nausea, in addition to having insomnia and not sleeping well, specifically endorsing having "a hallucination of Josh in my bedroom today." When asked about why she thinks this is occuring, she endorsed thinking about him a lot and feeling sad, and this was discussed as a type of grief reaction. Denies other symptoms of psychosis, AH, VH, no delusions or disorganized thought pattern. She was encouraged to continue to discuss and experience her emotions in therapy, and continues to request medication to help her symptoms.

MSE: 16 year old female, appearing thin and pale, wearing short shorts and a shirt tied showing her abdomen, unkempt with poor oral hygiene, acne on face, shoulders and legs, with poor eye contact, psychomotor agitation, and refusing to sit in the office so stood up throughout the visit. Speech slow rate, minimally spontaneous, normal rhythm, low volume. Mood "anxious and depressed" and affect congruent, constricted in range, appropriate, depressed and dysphoric, anxious. TP linear, GD, and TC without current SI, HI, VI, no current urges to self-harm, but ongoing urges to restrict calories and exercise compulsively, with endorsed illusion of past boyfriend, no other AVH, no delusions elicited, does not appear to respond to internal stimuli. Cognition grossly intact, I/J poor.

Impression/Formulation
Campbell is a 16 year old adopted Caucasian female with history of scoliosis surgery and rod placement January 2018, chronic pain and somatic symptoms related to the surgery, recent alleged sexual assault and breakup from her boyfriend one month ago, and reported symptoms of an unspecified eating disorder, who presents for admission to RTC due to symptoms of a major depressive disorder, self-injury and suicidal ideation the past month, and symptoms of anxiety, PTSD and somatic symptoms that have been treatment resistant to outpatient therapy and medication management. Of note, Campbell's self-report of historical events and psychiatric symptoms appear to be inconsistent at times and this has been described as similar to what her parents have noticed as well. Campbell is at elevated risk for harm to herself, due to history of impulsive self-injury and past SI, symptoms of treatment-resistant depression, anxiety, and ADHD in addition to chronic pain and recent impulsive and oppositional behaviors, and limited insight into her condition, though protective factors include access to mental health care, motivation for care and engagement in treatment, and supportive parents. She can be appropriately managed at an RTC level of care.

Diagnoses
MDD, severe, recurrent, without psychotic features
GAD
ADHD, combined type
unspecified somatic symptom disorder
Rule out PTSD, unspecified eating/feeding disorder, reactive attachment disorder, conversion disorder, BPD
BPD traits

Plan:
The client does not meet criteria for inpatient psychiatric admission or psychiatric hold at this time.

Clinical assessment is ongoing for diagnostic clarification.

Psychiatric Medications:
- Start melatonin 3mg po QHS for sleep onset insomnia
- Continue Zoloft 200mg for MDD and GAD, PTSD, for 8 months

- Continue Adderall XR 25mg daily PRN inattention, ADHD
- Continue Adderall IR 20mg daily PRN inattention, ADHD if not taking XR.
- May benefit from mirtazapine for insomnia, low appetite, will discuss with parents and psychiatrist. Awaiting call back from Dr. Starkey.

Medical:
- It was recommended to Campbell to inform staff when she is experiencing nausea and vomiting to record how often she is experiencing these symptoms and in which contexts.
- For migraines, Ibuprofen 600mg BID PRN migraine, headache, pain, and Tylenol 650mg BID PRN migraine, headache, pain
- Albuterol inhaler 2 puffs twice PRN SOB, wheezing, for asthma to use when playing sports.
- Start fish oil 1 capsule po BID
- Continue other current medications
- Gluten free diet
- Flonase nasal spray 1 spray each nostril daily PRN seasonal allergies
- Labs to include CMP, CBC with diff, prealbumin, iron, ferritin, TSH, 25-OH vitamin D, mag, phosphate, FSH, LH and estrogen, folate, urine hcg.
- ECG for QTc monitoring
- Recommend probiotic supplementation but client declines.
- Recommend nutritional consultation, meal buddy to encourage appropriate caloric intake, monitoring closely for excessive exercise, calorie restricting and purging.
- Will assess BMI and nutritional status with above labs.

Will maximize collateral with parents and outpatient clinicians.

Will plan to see weekly, sooner as needed for psychiatric assessment. Ongoing assessment needed for diagnostic clarification, treatment planning.

Recommend individual, group and family therapy. Recommend further exploration of grief symptoms.

Recommend engagement with healthy lifestyle learning including regular exercise, diet and mindfulness/meditation, in addition to other therapeutic resources available within the program.

Psychiatrist Signature:
--Digitally Signed: 10/03/2018 03:39 pm Medical Director Chelsea Neumann

Campbell Hatch
October 1, 2018 10:56am

Paradigm Malibu
Chelsea Neumann, M.D.

Psychiatrist Note

Client Name: Campbell Hatch
Date of Session: 10/01/2018
Admission Date: 09/30/2018

Note:
Psychiatric Evaluation

ID: Campbell is a 16 year old adopted Caucasian female with history of scoliosis surgery and rod placement January 2018, chronic pain and somatic symptoms related to the surgery, recent sexual assault and breakup from her boyfriend one month ago, oppositional behaviors, and symptoms of bulimia nervosa, who presents for admission to RTC due to symptoms of a major depressive disorder, self-injury and suicidal ideation the past month, and symptoms of anxiety and PTSD that have been treatment resistant to outpatient therapy and medication management.

HPI:
Today, Campbell endorses symptoms of depression, anxiety and is concerned mostly with her "bulimia."

Depression: Campbell endorses feeling hopeless, helpless, anhedonia, sadness about being told she cannot continue to dance competitively, low mood, mood swings, irritability, low appetite and insomnia. She believes these symptoms have been worse the past one month since her boyfriend cheated on her and they broke up, and since the "assault." See below for details.

Anxiety: Endorses panic attacks, sometimes waking her, chronic fatigue, always feeling tension in her body, insomnia (onset, middle awakening and early awakening) and waking up anxious, panicking, worrying about "everything."

Somatic symptoms: Surgery January 1st, resulting in chronic back spasms and distress, anxiety and panic when occurring, in addition to visual changes, somatic symptom of blindness, numbness and tingling in her extremities, and will seem "catatonic" per parents.

Eating disorder: Campbell endorses retricting calories, low appetite and not feeling hungry, worse while on Adderall, and exercising compulsively to lose weight. She describes feeling a sense of "control" when losing weight, and would like to work on this. Is aware of negative effects on mood caused by malnutrition. Assents to labs and ECG.

ADHD: inattention and hyperactivity, difficulty concentrating, but feels Adderall makes her "quiet and not talkative," but focused. Endorses desire to only take Adderall if doing school work.

SUD: Last cannabis and alcohol use one month ago, does believe she has a problem with drinking and cannabis and wants to quit. Was vaping nicotine in the past but has not used recently. No other illict drug use.

Per parents, Campbell has been engaging in oppositional and risky behaviors including stealing money and "framing" her sister, Client claims she has snuck out of the house although parents never caught her.
Telling people things that are not true (lying) for attention. Mom states that client has told people that mom is an alcoholic and abusive. Mom reports this is not true. Client took sister's car and went on a "joy ride." Client engaging in sexting behaviors. Mother describes Campbell having relationships with males online, but minimally in person and often believes she has relationships with males who she meets online. Mother describes Campbell being fascinated by a male who had a baby with another female in 8th grade due to being fascinated by a young couple keeping a baby, similar to her biological mother who did not keep her.

Trauma:
- Client endorsed sexual assault occuring one month ago by two eighth grade boys, chose not to discuss details today, but endorses feeling this causes her to feel anxious, no nightmares about it, reported it to the police but chose not to press charges. Per parents, was in movie theatre sitting between two boys and found her making out with them. Client told peers at school she was assaulted, though initially was joking about it and feeling like it was fun.

- Client witnessed her friend's grandmother dying in a nursing home by asphyxiation and endorses nightmares and anxiety/panic with flashbacks of the event.
- Medical trauma from surgeries.

PPH:
2018: Psychotherapy: Keeley Bailey (EMDR): Mom reports that client sees her weekly.
2016 – Current: Psychiatrist // Dr. Suzanne Starky // medication management

PMH:
- Summer of 6 th grade, client fell off a horse at camp, tore her meniscus. Knee Surgery: Summer of 7 th grade.
- Middle of 8 th grade: diagnosed with Scoliosis (atypical idiopathic) – Client had to wear a back brace to school. Had to undergo spinal injections. Eventual surgery: Jan 2018: had rods put in her back.
- Sept 8th : Client hit her head on a column during dance, had a concussion.
- LMP last week.
- History of febrile seizure
- History of benign murmur.
- Migraines

SH: Lives with adoptive parents since 5 days old, has not had contact with biological family but knows about them and would like to connect with them but must wait until age 18 due to agency rules. Was a competitive dancer but scoliosis pain has led her to have to quit dancing. She describes father as retreating when things are hard with her, feels he gets angry easily, and mother is "too involved," and describes feeling like neither parents understand her. Endorses having close friends who are supportive of her and understan what she is going through.
Education:
Baseline: Client has always experienced anxiety with going to school. She was diagnosed with ADHD in 1st grade and medicated. Mom reports client was always a B / C student, although smart enough to make B's. Mom reports she starts out doing well but then gets tired of going etc.. grades start to slide. Motivation begins to wane. Transferred from private school to public school in 4 th grade.
Current: Client has missed a lot of schooling due to medical issues and surgery. She has managed to stay on track and has been getting B's. Per Campbell, she thinks she is going to be expelled due to cursing at the teachers and principal.

Medications:
Adderall XR 25mg daily PRN ADHD, inattention
Adderall IR 20mg daily PRN if not taking Adderall XR, for ADHD, inattention
Loestrin Fe 1mg daily for oral contraception
Raw calcium 2 capsules po BID for calcium supplementation
Magnesium citrate 800mg po QHS for magnesium repletion
Zoloft 200mg po QHS
Flonase nasal spray as needed for allergies or congestion (PRN).

Allergies: Gluten sensitivity, gluten free diet

MSE: 16 year old female, appearing thin and pale, wearing short shorts and a shirt tied showing her abdomen, unkempt with poor oral hygiene, acne on face, shoulders and legs, with poor eye contact, psychomotor agitation, and refusing to sit in the office so was seen while walking the grounds of the facility. Speech slow rate, minimally spontaneous, normal rhythm, low volume. Mood "anxious and depressed" and affect congruent, constricted in range, appropriate, depressed and dysphoric, anxious. TP linear, GD, and TC without current SI, HI, VI, no current urges to self-harm, but ongoing urges to restrict calories and exercise compulsively, without AVH, no delusions elicited, does not appear to respond to internal stimuli. Cognition grossly intact, I/J poor.

Impression/Formulation
Campbell is a 16 year old adopted Caucasian female with history of scoliosis surgery and rod placement January 2018, chronic pain and somatic symptoms related to the surgery, recent sexual assault and breakup from her boyfriend one month ago, and symptoms of bulimia nervosa, who presents for admission to RTC due to symptoms of a major depressive disorder, self-injury and suicidal ideation the past month, and symptoms of anxiety and PTSD that have been treatment resistant to outpatient therapy and medication management. Campbell is at elevated risk for harm to herself, due to history of impulsive self-injury and past SI, symptoms of treatment-resistant depression, anxiety, and ADHD in addition to chronic pain and recent impulsive and oppositional behaviors, and limited insight into her

condition, though protective factors include access to mental health care, motivation for care and engagement in treatment, and supportive parents. She can be appropriately managed at an RTC level of care.

Diagnoses
MDD, severe, recurrent, without psychotic features
GAD
ADHD, combined type
Rule out PTSD, unspecified eating/feeding disorder, reactive attachment disorder, conversion disorder, BPD
BPD traits

Plan:
The client does not meet criteria for inpatient psychiatric admission or psychiatric hold at this time.

Clinical assessment is ongoing for diagnostic clarification.

Psychiatric Medications:
- Start melatonin 3mg po QHS for sleep onset insomnia
- Continue Zoloft 200mg for MDD and GAD, PTSD, for 8 months
- Continue Adderall XR 25mg daily PRN inattention, ADHD
- Continue Adderall IR 20mg daily PRN inattention, ADHD if not taking XR.
- May benefit from mirtazapine for insomnia, low appetite, will discuss with parents and psychiatrist.

Medical:
- For migraines, Ibuprofen 600mg BID PRN migraine, headache, pain, and Tylenol 650mg BID PRN migraine, headache, pain
- Albuterol inhaler 2 puffs twice PRN SOB, wheezing, for asthma to use when playing sports.
- Start fish oil 1 capsule po BID
- Continue other current medications
- Gluten free diet
- Flonase nasal spray 1 spray each nostril daily PRN seasonal allergies
- Labs to include CMP, CBC with diff, prealbumin, iron, ferritin, TSH, 25-OH vitamin D, mag, phosphate, FSH, LH and estrogen, folate, urine hcg.
- ECG for QTc monitoring
- Recommend probiotic supplementation but client declines.
- Recommend nutritional consultation, meal buddy to encourage appropriate caloric intake, monitoring closely for excessive exercise, calorie restricting and purging.
- Will assess BMI and nutritional status with above labs.

Will maximize collateral with parents and outpatient clinicians.

Will plan to see weekly, sooner as needed for psychiatric assessment. Ongoing assessment needed for diagnostic clarification, treatment planning.

Recommend individual, group and family therapy. Recommend further exploration of grief symptoms.
2
Recommend engagement with healthy lifestyle learning including regular exercise, diet and mindfulness/meditation, in addition to other therapeutic resources available within the program.

Psychiatrist Signature:
--Digitally Signed: 10/01/2018 04:33 pm Medical Director Chelsea Neumann

Campbell Hatch
November 12, 2018 6:26pm

Paradigm Malibu
Chelsea Neumann, M.D.

Psychiatrist Note

Client Name: Campbell Hatch
Date of Session: 11/12/2018
Admission Date: 09/30/2018

Note:
Psychiatric Review

Interval history
Campbell seen today for final review before discharge. She is looking forward to returning home though endorses anxiety about this. Plans to engage in IOP and see her individual therapist and psychiatrist after. Endorses improvement in emotion regulation, depression and feels more aware of the destructive nature of her dishonesty which often distracts her from dealing with her emotional problems. Maintains she has been sexually assaulted and fixates on this as her main stressor. Is looking forward to returning home with her family and "move on with my life." Anticipatory guidance provided regarding return to home, school and social setting. Has been tolerating the evacuation due to fires well, but today had a headache and has been refusing to engage in treatment programming.

Tolerating medications (sertraline 200mg, Vyvanse 45mg and Seroquel 25mg) well, sleep has improved and she endorses improvement in mood lability, extreme anxiety and panic attacks since initiation of Seroquel. Would like to continue this medication.

MSE: 16 year old female, appearing better kempt, well groomed, good eye contact, psychomotor normal, sitting in a chair, calm and cooperative. Speech normal rate, rhythm and volume. Mood "better, more even" and affect congruent, constricted in range, appropriate, euthymic. TP linear, GD, and TC without current SI, HI, VI, no AVH, no delusions elicited, does not appear to respond to internal stimuli. Cognition grossly intact, I/J improving.

Labs completed 10/4/18:
iron, ferriting and MCHC low indication iron deficiency anemia.

Impression/Formulation
Campbell is a 16 year old adopted Caucasian female with history of scoliosis surgery and rod placement January 2018, chronic pain and somatic symptoms related to the surgery, recent alleged sexual assault and breakup from her boyfriend one month ago, and reported symptoms of an unspecified eating disorder, who presents for admission to RTC due to symptoms of a major depressive disorder, self-injury and suicidal ideation the past month, and symptoms of anxiety, PTSD and somatic symptoms that have been treatment resistant to outpatient therapy and medication management. Today, she endorsed SI and feeling overwhelmed and unable to understand her emotions and why she lies, but later engaged in discussion about how difficult it is to address her true feelings without hiding being stories she makes up about her life. Of note, Campbell's self-report of historical events and psychiatric symptoms appear to be inconsistent at times and this has been described as similar to what her parents have noticed as well. Campbell is at elevated risk for harm to herself, due to history of impulsive self-injury and past SI, symptoms of treatment-resistant depression, anxiety, and ADHD in addition to chronic pain and recent impulsive and oppositional behaviors, and limited insight into her condition, though protective factors include access to mental health care, motivation for care and engagement in treatment, and supportive parents. She can be appropriately managed at an RTC level of care. Plan for discharge to home with ongoing psychotherapy and IOP level of care.

Diagnoses
MDD, severe, recurrent, without psychotic features
GAD
ADHD, combined type
Somatic symptom disorder
Factitious disorder
Rule out PTSD, unspecified eating/feeding disorder, reactive attachment disorder, conversion disorder, BPD
BPD/HPD traits

Plan:
The client does not meet criteria for inpatient psychiatric admission or psychiatric hold at this time.

Clinical assessment is ongoing for diagnostic clarification.

Psychiatric Medications:
- Continue Seroquel 25mg po QHS for mood stabilization, augmentation of SSRI.
- Continue melatonin 3mg po QHS for sleep onset insomnia
- Continue Zoloft 200mg for MDD and GAD, PTSD
- Continue Vyvanse 25mg daily for inattention, ADHD
- Continue Adderall IR 20mg daily PRN inattention, ADHD if not taking XR.

Medical:
- Prune juice has been discontinued.
- For migraines, Ibuprofen 600mg BID PRN migraine, headache, pain, and Tylenol 650mg BID PRN migraine, headache, pain
- Albuterol inhaler 2 puffs twice PRN SOB, wheezing, for asthma to use when playing sports.
- Continue fish oil 1 capsule po BID
- Continue other current medications
- Gluten free diet
- Flonase nasal spray 1 spray each nostril daily PRN seasonal allergies
- Recommend probiotic supplementation but client declines.
- Recommend nutritional consultation, meal buddy to encourage appropriate caloric intake, monitoring closely for excessive exercise, calorie restricting and purging.
- Nutritional status significant for iron deficiency anemia, treated with iron supplementation and Vitamin C.

Plan for discharge tomorrow.
Recommend IOP level of care, ongoing individual and family therapy upon discharge.

Recommend engagement with healthy lifestyle learning including regular exercise, diet and mindfulness/meditation, in addition to other therapeutic resources available within the program, and in her community.

Psychiatrist Signature:
--Digitally Signed: 11/12/2018 06:32 pm Medical Director Chelsea Neumann, M.D.

Campbell Hatch
November 3, 2018 12:04pm

Paradigm Malibu
Chelsea Neumann, M.D.

Psychiatrist Note

Client Name: Campbell Hatch
Date of Session: 11/03/2018
Admission Date: 09/30/2018

Note:
Psychiatric review

Campbell seen today, endorses improvement in mood stability and anxiety since initiation of quetiapine 25mg at bedtime, tolerating well and sleeping well. Appetite has also improved. Denies AEs. Endorses progress in therapy the past couple of weeks, discussing openly her anxiety about her adoption, triggers that remind her of the sexual assault. She denies intention and plan to harm herself or others, denies perceptual disturbances, psychotic symptoms. Looking forward to family day and returning home, feels closer to her parents and is forgiving herself and parents for her adoption.

MSE: 16 year old female, appearing better kempt, well groomed, good eye contact, psychomotor normal, sitting in a chair, calm and cooperative. Speech normal rate, rhythm and volume. Mood "better, more even" and affect congruent, constricted in range, appropriate, euthymic. TP linear, GD, and TC without current SI, HI, VI, no AVH, no delusions elicited, does not appear to respond to internal stimuli. Cognition grossly intact, I/J improving.

Labs completed 10/4/18:
iron, ferriting and MCHC low indication iron deficiency anemia.

Impression/Formulation
Campbell is a 16 year old adopted Caucasian female with history of scoliosis surgery and rod placement January 2018, chronic pain and somatic symptoms related to the surgery, recent alleged sexual assault and breakup from her boyfriend one month ago, and reported symptoms of an unspecified eating disorder, who presents for admission to RTC due to symptoms of a major depressive disorder, self-injury and suicidal ideation the past month, and symptoms of anxiety, PTSD and somatic symptoms that have been treatment resistant to outpatient therapy and medication management. Today, she endorsed SI and feeling overwhelmed and unable to understand her emotions and why she lies, but later engaged in discussion about how difficult it is to address her true feelings without hiding being stories she makes up about her life. Of note, Campbell's self-report of historical events and psychiatric symptoms appear to be inconsistent at times and this has been described as similar to what her parents have noticed as well. Campbell is at elevated risk for harm to herself, due to history of impulsive self-injury and past SI, symptoms of treatment-resistant depression, anxiety, and ADHD in addition to chronic pain and recent impulsive and oppositional behaviors, and limited insight into her condition, though protective factors include access to mental health care, motivation for care and engagement in treatment, and supportive parents. She can be appropriately managed at an RTC level of care.

Diagnoses
MDD, severe, recurrent, without psychotic features
GAD
ADHD, combined type
unspecified somatic symptom disorder
Factitious disorder
Rule out PTSD, unspecified eating/feeding disorder, reactive attachment disorder, conversion disorder, BPD
BPD/HPD traits

Plan:
The client does not meet criteria for inpatient psychiatric admission or psychiatric hold at this time.

Clinical assessment is ongoing for diagnostic clarification.

Psychiatric Medications:

- Continue Seroquel 25mg po QHS for mood stabilization, augmentation of SSRI.
- Continue melatonin 3mg po QHS for sleep onset insomnia
- Continue Zoloft 200mg for MDD and GAD, PTSD
- Continue Adderall XR 25mg daily PRN inattention, ADHD
- Continue Adderall IR 20mg daily PRN inattention, ADHD if not taking XR.

Medical:
- Prune juice has been discontinued.
- For migraines, Ibuprofen 600mg BID PRN migraine, headache, pain, and Tylenol 650mg BID PRN migraine, headache, pain
- Albuterol inhaler 2 puffs twice PRN SOB, wheezing, for asthma to use when playing sports.
- Continue fish oil 1 capsule po BID
- Continue other current medications
- Gluten free diet
- Flonase nasal spray 1 spray each nostril daily PRN seasonal allergies
- Recommend probiotic supplementation but client declines.
- Recommend nutritional consultation, meal buddy to encourage appropriate caloric intake, monitoring closely for excessive exercise, calorie restricting and purging.
- Nutritional status significant for iron deficiency anemia, treated with iron supplementation and Vitamin C.

Will maximize collateral with parents and outpatient clinicians.

Will plan to see weekly, sooner as needed for psychiatric assessment. Ongoing assessment needed for diagnostic clarification, treatment planning.

Recommend individual, group and family therapy. Recommend further exploration of grief symptoms.

Recommend engagement with healthy lifestyle learning including regular exercise, diet and mindfulness/meditation, in addition to other therapeutic resources available within the program.

Psychiatrist Signature:
--Digitally Signed: 11/03/2018 12:09 pm Medical Director Chelsea Neumann, M.D.

Campbell Hatch
October 18, 2018 5:37pm

Paradigm Malibu
Chelsea Neumann, M.D.

Psychiatrist Note

Client Name: Campbell Hatch
Date of Session: 10/18/2018
Admission Date: 09/30/2018

Note:
Psychiatric review

Interval History
Campbell seen today, endorses feeling overwhelmed, described "hearing voices of my mother and Josh," saying nonspecific things, and endorsed "feeling suicidal," with plans to "slit my throat or drown myself." She denied intention to do so while at Paradigm, and denied having means with which to execute these plans. She endorsed feeling anxious, in distress, and "like I don't know what's real any more," and requested support from the team. She endorsed "actually dancing on a pole and having a pimp in the past, but not recently," and "I lost my baby, and my parents didn't know." She responded well to deep breathing, went for a walk with staff, and then later engaged in therapy session during which she discussed feeling unable to control her story-telling about untrue experiences she has had, and shared her sadness and feelings of worthlessness related to her adoption. She was held back from the outing, and remained on 1:1 until this evening.

Perry, mother, contacted and recommendation provided to start Seroquel 25mg for augmentation of Zoloft and mood stabilization, dissociative symptoms. Mother consented to a trial. Email sent to father requesting to discuss, as he was already in bed.

MSE: 16 year old female, appearing thin and pale, unkempt, disheveled, tearful, with poor eye contact, psychomotor agitation, sitting in a chair. Speech slow rate, normal rhythm, low volume. Mood "suicidal, sad" and affect congruent, constricted in range, appropriate, depressed and dysphoric, anxious, tearful at times. TP linear, GD, and TC with current SI, plan to "slit my throat" but without intention, without HI, VI, complaining of AH of her mother and male peer's voice, no delusions elicited, does not appear to respond to internal stimuli. Cognition grossly intact, I/J poor.

Labs completed 10/4/18:
iron, ferriting and MCHC low indication iron deficiency anemia.

Impression/Formulation
Campbell is a 16 year old adopted Caucasian female with history of scoliosis surgery and rod placement January 2018, chronic pain and somatic symptoms related to the surgery, recent alleged sexual assault and breakup from her boyfriend one month ago, and reported symptoms of an unspecified eating disorder, who presents for admission to RTC due to symptoms of a major depressive disorder, self-injury and suicidal ideation the past month, and symptoms of anxiety, PTSD and somatic symptoms that have been treatment resistant to outpatient therapy and medication management. Today, she endorsed SI and feeling overwhelmed and unable to understand her emotions and why she lies, but later engaged in discussion about how difficult it is to address her true feelings without hiding being stories she makes up about her life. Of note, Campbell's self-report of historical events and psychiatric symptoms appear to be inconsistent at times and this has been described as similar to what her parents have noticed as well. Campbell is at elevated risk for harm to herself, due to history of impulsive self-injury and past SI, symptoms of treatment-resistant depression, anxiety, and ADHD in addition to chronic pain and recent impulsive and oppositional behaviors, and limited insight into her condition, though protective factors include access to mental health care, motivation for care and engagement in treatment, and supportive parents. She can be appropriately managed at an RTC level of care.

Diagnoses
MDD, severe, recurrent, without psychotic features
GAD
ADHD, combined type
unspecified somatic symptom disorder
Rule out PTSD, unspecified eating/feeding disorder, reactive attachment disorder, conversion disorder, BPD

BPD/HPD traits

Plan:
The client does not meet criteria for inpatient psychiatric admission or psychiatric hold at this time.

Clinical assessment is ongoing for diagnostic clarification.

Psychiatric Medications:
- Start Seroquel 25mg po QHS for mood stabilization, augmentation of SSRI.
- Continue melatonin 3mg po QHS for sleep onset insomnia
- Continue Zoloft 200mg for MDD and GAD, PTSD
- Continue Adderall XR 25mg daily PRN inattention, ADHD
- Continue Adderall IR 20mg daily PRN inattention, ADHD if not taking XR.

Medical:
- Continue prune juice daily for constipation
- For migraines, Ibuprofen 600mg BID PRN migraine, headache, pain, and Tylenol 650mg BID PRN migraine, headache, pain
- Albuterol inhaler 2 puffs twice PRN SOB, wheezing, for asthma to use when playing sports.
- Continue fish oil 1 capsule po BID
- Continue other current medications
- Gluten free diet
- Flonase nasal spray 1 spray each nostril daily PRN seasonal allergies
- Recommend probiotic supplementation but client declines.
- Recommend nutritional consultation, meal buddy to encourage appropriate caloric intake, monitoring closely for excessive exercise, calorie restricting and purging.
- Nutritional status significant for iron deficiency anemia, and has been started on iron supplementation and Vitamin C.

Will maximize collateral with parents and outpatient clinicians.

Will plan to see weekly, sooner as needed for psychiatric assessment. Ongoing assessment needed for diagnostic clarification, treatment planning.

Recommend individual, group and family therapy. Recommend further exploration of grief symptoms.

Recommend engagement with healthy lifestyle learning including regular exercise, diet and mindfulness/meditation, in addition to other therapeutic resources available within the program.

Psychiatrist Signature:
--Digitally Signed: 10/18/2018 06:10 pm Medical Director Chelsea Neumann, M.D.

Campbell Hatch
October 9, 2018 4:40pm

Paradigm Malibu
Chelsea Neumann, M.D.

Psychiatrist Note

Client Name: Campbell Hatch
Date of Session: 10/09/2018
Admission Date: 09/30/2018

Note:
Psychiatric review

Interval history

Complained of constipation, left lower quadrant discomfort and fullness, has not had a BM for 2 days. Agrees to try prune juice daily.

Campbell complained of headache, saying her headaches are severe and prevent her from engaging in her therapy and school work during the day. She endorsed worrying recently about "the assault." She was challenged to be authentic about her suffering and real emotions, to validate her suffering about her surgery, loss of dance, and worries about her biological family members, and she became tearful and said she worries about her biological sister and if she is okay in the foster system, endorses guilt for being adopted and having a stable household, and feels resentful toward her biological mother for separating her from her siblings and the adoption agency for not letting her have contact with them. She was encouraged to continue to feel and process these emotions in therapy, and to avoid distraction and therapy-interfering behaviors including becoming obsessed with factitious relationships and experiences. She was validated that her sexual experience that occured in the movie theatre may have been assault, and if so to appropriately process it in therapy, instead of making it into a joke to laugh about.

Campbell endorsed desire to talk about her real feelings, but endorses feeling "it is too hard, they hurt." She was encouraged to show herself and explore in herself who she is and how to care for herself.

MSE: 16 year old female, appearing thin and pale, dressed wearing pants and a sweater, improved self-care, hair newly washed, acne on face, shoulders and legs, with poor eye contact, psychomotor agitation, but eventually calmed and sat in a chair. Speech slow rate, minimally spontaneous, normal rhythm, low volume. Mood "worried and sad" and affect congruent, constricted in range, appropriate, depressed and dysphoric, anxious, tearful at times. TP linear, GD, and TC without current SI, HI, VI, no current urges to self-harm, no AVH, no delusions elicited, does not appear to respond to internal stimuli. Cognition grossly intact, I/J poor.

Labs completed 10/4/18:
iron, ferriting and MCHC low indication iron deficiency anemia.

Impression/Formulation
Campbell is a 16 year old adopted Caucasian female with history of scoliosis surgery and rod placement January 2018, chronic pain and somatic symptoms related to the surgery, recent alleged sexual assault and breakup from her boyfriend one month ago, and reported symptoms of an unspecified eating disorder, who presents for admission to RTC due to symptoms of a major depressive disorder, self-injury and suicidal ideation the past month, and symptoms of anxiety, PTSD and somatic symptoms that have been treatment resistant to outpatient therapy and medication management. Of note, Campbell's self-report of historical events and psychiatric symptoms appear to be inconsistent at times and this has been described as similar to what her parents have noticed as well. Campbell is at elevated risk for harm to herself, due to history of impulsive self-injury and past SI, symptoms of treatment-resistant depression, anxiety, and ADHD in addition to chronic pain and recent impulsive and oppositional behaviors, and limited insight into her condition, though protective factors include access to mental health care, motivation for care and engagement in treatment, and supportive parents. She can be appropriately managed at an RTC level of care.

Diagnoses
MDD, severe, recurrent, without psychotic features
GAD

ADHD, combined type
unspecified somatic symptom disorder
Rule out PTSD, unspecified eating/feeding disorder, reactive attachment disorder, conversion disorder, BPD
BPD traits

Plan:
The client does not meet criteria for inpatient psychiatric admission or psychiatric hold at this time.

Clinical assessment is ongoing for diagnostic clarification.

Psychiatric Medications:
- Continue melatonin 3mg po QHS for sleep onset insomnia
- Continue Zoloft 200mg for MDD and GAD, PTSD
- Continue Adderall XR 25mg daily PRN inattention, ADHD
- Continue Adderall IR 20mg daily PRN inattention, ADHD if not taking XR.

Medical:
- Start prune juice daily for constipation
- It was recommended to Campbell to inform staff when she is experiencing nausea and vomiting to record how often she is experiencing these symptoms and in which contexts.
- For migraines, Ibuprofen 600mg BID PRN migraine, headache, pain, and Tylenol 650mg BID PRN migraine, headache, pain
- Albuterol inhaler 2 puffs twice PRN SOB, wheezing, for asthma to use when playing sports.
- Continue fish oil 1 capsule po BID
- Continue other current medications
- Gluten free diet
- Flonase nasal spray 1 spray each nostril daily PRN seasonal allergies
- Recommend probiotic supplementation but client declines.
- Recommend nutritional consultation, meal buddy to encourage appropriate caloric intake, monitoring closely for excessive exercise, calorie restricting and purging.
- Nutritional status significant for iron deficiency anemia, and has been started on iron supplementation and Vitamin C.

Will maximize collateral with parents and outpatient clinicians.

Will plan to see weekly, sooner as needed for psychiatric assessment. Ongoing assessment needed for diagnostic clarification, treatment planning.

Recommend individual, group and family therapy. Recommend further exploration of grief symptoms.

Recommend engagement with healthy lifestyle learning including regular exercise, diet and mindfulness/meditation, in addition to other therapeutic resources available within the program.

Psychiatrist Signature:
--Digitally Signed: 10/09/2018 04:50 pm Medical Director Chelsea Neumann

Campbell Hatch
October 3, 2018 3:25pm

Paradigm Malibu
Chelsea Neumann, M.D.

Psychiatrist Note

Client Name: Campbell Hatch
Date of Session: 10/03/2018
Admission Date: 09/30/2018

Note:
Psychiatric review

Interval history
Campbell seen today, endorses ongoing anxiety, feeling nauseated and requesting Zofran due to nausea, in addition to having insomnia and not sleeping well, specifically endorsing having "a hallucination of Josh in my bedroom today." When asked about why she thinks this is occuring, she endorsed thinking about him a lot and feeling sad, and this was discussed as a type of grief reaction. Denies other symptoms of psychosis, AH, VH, no delusions or disorganized thought pattern. She was encouraged to continue to discuss and experience her emotions in therapy, and continues to request medication to help her symptoms.

MSE: 16 year old female, appearing thin and pale, wearing short shorts and a shirt tied showing her abdomen, unkempt with poor oral hygiene, acne on face, shoulders and legs, with poor eye contact, psychomotor agitation, and refusing to sit in the office so stood up throughout the visit. Speech slow rate, minimally spontaneous, normal rhythm, low volume. Mood "anxious and depressed" and affect congruent, constricted in range, appropriate, depressed and dysphoric, anxious. TP linear, GD, and TC without current SI, HI, VI, no current urges to self-harm, but ongoing urges to restrict calories and exercise compulsively, with endorsed illusion of past boyfriend, no other AVH, no delusions elicited, does not appear to respond to internal stimuli. Cognition grossly intact, I/J poor.

Impression/Formulation
Campbell is a 16 year old adopted Caucasian female with history of scoliosis surgery and rod placement January 2018, chronic pain and somatic symptoms related to the surgery, recent alleged sexual assault and breakup from her boyfriend one month ago, and reported symptoms of an unspecified eating disorder, who presents for admission to RTC due to symptoms of a major depressive disorder, self-injury and suicidal ideation the past month, and symptoms of anxiety, PTSD and somatic symptoms that have been treatment resistant to outpatient therapy and medication management. Of note, Campbell's self-report of historical events and psychiatric symptoms appear to be inconsistent at times and this has been described as similar to what her parents have noticed as well. Campbell is at elevated risk for harm to herself, due to history of impulsive self-injury and past SI, symptoms of treatment-resistant depression, anxiety, and ADHD in addition to chronic pain and recent impulsive and oppositional behaviors, and limited insight into her condition, though protective factors include access to mental health care, motivation for care and engagement in treatment, and supportive parents. She can be appropriately managed at an RTC level of care.

Diagnoses
MDD, severe, recurrent, without psychotic features
GAD
ADHD, combined type
unspecified somatic symptom disorder
Rule out PTSD, unspecified eating/feeding disorder, reactive attachment disorder, conversion disorder, BPD
BPD traits

Plan:
The client does not meet criteria for inpatient psychiatric admission or psychiatric hold at this time.

Clinical assessment is ongoing for diagnostic clarification.

Psychiatric Medications:
- Start melatonin 3mg po QHS for sleep onset insomnia
- Continue Zoloft 200mg for MDD and GAD, PTSD, for 8 months

- Continue Adderall XR 25mg daily PRN inattention, ADHD
- Continue Adderall IR 20mg daily PRN inattention, ADHD if not taking XR.
- May benefit from mirtazapine for insomnia, low appetite, will discuss with parents and psychiatrist. Awaiting call back from Dr. Starkey.

Medical:
- It was recommended to Campbell to inform staff when she is experiencing nausea and vomiting to record how often she is experiencing these symptoms and in which contexts.
- For migraines, Ibuprofen 600mg BID PRN migraine, headache, pain, and Tylenol 650mg BID PRN migraine, headache, pain
- Albuterol inhaler 2 puffs twice PRN SOB, wheezing, for asthma to use when playing sports.
- Start fish oil 1 capsule po BID
- Continue other current medications
- Gluten free diet
- Flonase nasal spray 1 spray each nostril daily PRN seasonal allergies
- Labs to include CMP, CBC with diff, prealbumin, iron, ferritin, TSH, 25-OH vitamin D, mag, phosphate, FSH, LH and estrogen, folate, urine hcg.
- ECG for QTc monitoring
- Recommend probiotic supplementation but client declines.
- Recommend nutritional consultation, meal buddy to encourage appropriate caloric intake, monitoring closely for excessive exercise, calorie restricting and purging.
- Will assess BMI and nutritional status with above labs.

Will maximize collateral with parents and outpatient clinicians.

Will plan to see weekly, sooner as needed for psychiatric assessment. Ongoing assessment needed for diagnostic clarification, treatment planning.

Recommend individual, group and family therapy. Recommend further exploration of grief symptoms.

Recommend engagement with healthy lifestyle learning including regular exercise, diet and mindfulness/meditation, in addition to other therapeutic resources available within the program.

Psychiatrist Signature:
--Digitally Signed: 10/03/2018 03:39 pm Medical Director Chelsea Neumann

Campbell Hatch
October 1, 2018 10:56am

Paradigm Malibu
Chelsea Neumann, M.D.

Psychiatrist Note

Client Name: Campbell Hatch
Date of Session: 10/01/2018
Admission Date: 09/30/2018

Note:
Psychiatric Evaluation

ID: Campbell is a 16 year old adopted Caucasian female with history of scoliosis surgery and rod placement January 2018, chronic pain and somatic symptoms related to the surgery, recent sexual assault and breakup from her boyfriend one month ago, oppositional behaviors, and symptoms of bulimia nervosa, who presents for admission to RTC due to symptoms of a major depressive disorder, self-injury and suicidal ideation the past month, and symptoms of anxiety and PTSD that have been treatment resistant to outpatient therapy and medication management.

HPI:
Today, Campbell endorses symptoms of depression, anxiety and is concerned mostly with her "bulimia."

Depression: Campbell endorses feeling hopeless, helpless, anhedonia, sadness about being told she cannot continue to dance competitively, low mood, mood swings, irritability, low appetite and insomnia. She believes these symptoms have been worse the past one month since her boyfriend cheated on her and they broke up, and since the "assault." See below for details.

Anxiety: Endorses panic attacks, sometimes waking her, chronic fatigue, always feeling tension in her body, insomnia (onset, middle awakening and early awakening) and waking up anxious, panicking, worrying about "everything."

Somatic symptoms: Surgery January 1st, resulting in chronic back spasms and distress, anxiety and panic when occurring, in addition to visual changes, somatic symptom of blindness, numbness and tingling in her extremities, and will seem "catatonic" per parents.

Eating disorder: Campbell endorses retricting calories, low appetite and not feeling hungry, worse while on Adderall, and exercising compulsively to lose weight. She describes feeling a sense of "control" when losing weight, and would like to work on this. Is aware of negative effects on mood caused by malnutrition. Assents to labs and ECG.

ADHD: inattention and hyperactivity, difficulty concentrating, but feels Adderall makes her "quiet and not talkative," but focused. Endorses desire to only take Adderall if doing school work.

SUD: Last cannabis and alcohol use one month ago, does believe she has a problem with drinking and cannabis and wants to quit. Was vaping nicotine in the past but has not used recently. No other illict drug use.

Per parents, Campbell has been engaging in oppositional and risky behaviors including stealing money and "framing" her sister, Client claims she has snuck out of the house although parents never caught her.
Telling people things that are not true (lying) for attention. Mom states that client has told people that mom is an alcoholic and abusive. Mom reports this is not true. Client took sister's car and went on a "joy ride." Client engaging in sexting behaviors. Mother describes Campbell having relationships with males online, but minimally in person and often believes she has relationships with males who she meets online. Mother describes Campbell being fascinated by a male who had a baby with another female in 8th grade due to being fascinated by a young couple keeping a baby, similar to her biological mother who did not keep her.

Trauma:
- Client endorsed sexual assault occuring one month ago by two eighth grade boys, chose not to discuss details today, but endorses feeling this causes her to feel anxious, no nightmares about it, reported it to the police but chose not to press charges. Per parents, was in movie theatre sitting between two boys and found her making out with them. Client told peers at school she was assaulted, though initially was joking about it and feeling like it was fun.

- Client witnessed her friend's grandmother dying in a nursing home by asphyxiation and endorses nightmares and anxiety/panic with flashbacks of the event.
- Medical trauma from surgeries.

PPH:
2018: Psychotherapy: Keeley Bailey (EMDR): Mom reports that client sees her weekly.
2016 – Current: Psychiatrist // Dr. Suzanne Starky // medication management

PMH:
- Summer of 6 th grade, client fell off a horse at camp, tore her meniscus. Knee Surgery: Summer of 7 th grade.
- Middle of 8 th grade: diagnosed with Scoliosis (atypical idiopathic) – Client had to wear a back brace to school. Had to undergo spinal injections. Eventual surgery: Jan 2018: had rods put in her back.
- Sept 8th : Client hit her head on a column during dance, had a concussion.
- LMP last week.
- History of febrile seizure
- History of benign murmur.
- Migraines

SH: Lives with adoptive parents since 5 days old, has not had contact with biological family but knows about them and would like to connect with them but must wait until age 18 due to agency rules. Was a competitive dancer but scoliosis pain has led her to have to quit dancing. She describes father as retreating when things are hard with her, feels he gets angry easily, and mother is "too involved," and describes feeling like neither parents understand her. Endorses having close friends who are supportive of her and understan what she is going through.
Education:
Baseline: Client has always experienced anxiety with going to school. She was diagnosed with ADHD in 1st grade and medicated. Mom reports client was always a B / C student, although smart enough to make B's. Mom reports she starts out doing well but then gets tired of going etc.. grades start to slide. Motivation begins to wane. Transferred from private school to public school in 4 th grade.
Current: Client has missed a lot of schooling due to medical issues and surgery. She has managed to stay on track and has been getting B's. Per Campbell, she thinks she is going to be expelled due to cursing at the teachers and principal.

Medications:
Adderall XR 25mg daily PRN ADHD, inattention
Adderall IR 20mg daily PRN if not taking Adderall XR, for ADHD, inattention
Loestrin Fe 1mg daily for oral contraception
Raw calcium 2 capsules po BID for calcium supplementation
Magnesium citrate 800mg po QHS for magnesium repletion
Zoloft 200mg po QHS
Flonase nasal spray as needed for allergies or congestion (PRN).

Allergies: Gluten sensitivity, gluten free diet

MSE: 16 year old female, appearing thin and pale, wearing short shorts and a shirt tied showing her abdomen, unkempt with poor oral hygiene, acne on face, shoulders and legs, with poor eye contact, psychomotor agitation, and refusing to sit in the office so was seen while walking the grounds of the facility. Speech slow rate, minimally spontaneous, normal rhythm, low volume. Mood "anxious and depressed" and affect congruent, constricted in range, appropriate, depressed and dysphoric, anxious. TP linear, GD, and TC without current SI, HI, VI, no current urges to self-harm, but ongoing urges to restrict calories and exercise compulsively, without AVH, no delusions elicited, does not appear to respond to internal stimuli. Cognition grossly intact, I/J poor.

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Campbell is a 16 year old adopted Caucasian female with history of scoliosis surgery and rod placement January 2018, chronic pain and somatic symptoms related to the surgery, recent sexual assault and breakup from her boyfriend one month ago, and symptoms of bulimia nervosa, who presents for admission to RTC due to symptoms of a major depressive disorder, self-injury and suicidal ideation the past month, and symptoms of anxiety and PTSD that have been treatment resistant to outpatient therapy and medication management. Campbell is at elevated risk for harm to herself, due to history of impulsive self-injury and past SI, symptoms of treatment-resistant depression, anxiety, and ADHD in addition to chronic pain and recent impulsive and oppositional behaviors, and limited insight into her

condition, though protective factors include access to mental health care, motivation for care and engagement in treatment, and supportive parents. She can be appropriately managed at an RTC level of care.

Diagnoses
MDD, severe, recurrent, without psychotic features
GAD
ADHD, combined type
Rule out PTSD, unspecified eating/feeding disorder, reactive attachment disorder, conversion disorder, BPD
BPD traits

Plan:
The client does not meet criteria for inpatient psychiatric admission or psychiatric hold at this time.

Clinical assessment is ongoing for diagnostic clarification.

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- Continue Adderall IR 20mg daily PRN inattention, ADHD if not taking XR.
- May benefit from mirtazapine for insomnia, low appetite, will discuss with parents and psychiatrist.

Medical:
- For migraines, Ibuprofen 600mg BID PRN migraine, headache, pain, and Tylenol 650mg BID PRN migraine, headache, pain
- Albuterol inhaler 2 puffs twice PRN SOB, wheezing, for asthma to use when playing sports.
- Start fish oil 1 capsule po BID
- Continue other current medications
- Gluten free diet
- Flonase nasal spray 1 spray each nostril daily PRN seasonal allergies
- Labs to include CMP, CBC with diff, prealbumin, iron, ferritin, TSH, 25-OH vitamin D, mag, phosphate, FSH, LH and estrogen, folate, urine hcg.
- ECG for QTc monitoring
- Recommend probiotic supplementation but client declines.
- Recommend nutritional consultation, meal buddy to encourage appropriate caloric intake, monitoring closely for excessive exercise, calorie restricting and purging.
- Will assess BMI and nutritional status with above labs.

Will maximize collateral with parents and outpatient clinicians.

Will plan to see weekly, sooner as needed for psychiatric assessment. Ongoing assessment needed for diagnostic clarification, treatment planning.

Recommend individual, group and family therapy. Recommend further exploration of grief symptoms.
2
Recommend engagement with healthy lifestyle learning including regular exercise, diet and mindfulness/meditation, in addition to other therapeutic resources available within the program.

Psychiatrist Signature:
--Digitally Signed: 10/01/2018 04:33 pm Medical Director Chelsea Neumann

paradigm TREATMENT CENTERS malibu

parent intake

Interviewer Name: Cindy Weathers
Date: 9/30/18

Client Info:

Name: Campbell Hatch **Birthdate**: 7/19/02 **Age**: 16 **Year In School:** 10th

Parents/Guardians Contact Info:

Mom: Perry Hatch // (404) 907-6283 // jettphatch@bellsouth.net OR perry.hatch@wolterskluwer.com
Dad: Paul Hatch // (404) 307-6560 // paul.hatch@benefits4hr.com

Other Family Member Info:

Sister: Jett (20): Away at college

Primary Concerns:

Somatic pain: Client underwent spinal surgery for Scoliosis in Jan 2018. She had rods put in her back and struggled with severe pain and back spasms before and after the surgery. Client continues to struggle with psycho-somatic symptoms where she will have intense back spasms and episodes of numbness, tingling (loses feeling) in legs and fingers and back spasms. Client has experienced "temporary blindness" as well during these episodes and paralysis. Mom reports that client will go into a "catatonic like state" and that client says she loses her vision for approx. 30-40 minutes. Onset of pain a few years ago, catatonic phase and episodes of blindness happening every other week since July of this year.

ADHD: Client tested and diagnosed 1st grade, hyperactive and inattentive type (mom will send testing)– doctor immediately put her on Adderall. Client was retested after concussion, Dec of 8th grade, processing differences and client received some accommodations at school.

Anxiety: Onset early on, probably Kindergarten, every day before school she would say her stomach hurt. Parents would get her to school and she would make it to school. She would also report "stage fright" with dancing. Anxiety became more prevalent with medical issues, especially when she's in pain from her back. She begins to lose feelings in fingers, toes and legs and gets to the point where there is "no life in her eyes." "Catatonic like state" when she has pain from rods in her back. In 6th, 7th grade client was reporting panic attacks although mom never witnessed a panic attack.

Depression: Approx. 2 year ago, client started taking Zoloft, started sleeping in her bed and then would go into parent's bed around 2am due to being afraid. Couldn't sleep at night. Dr. Starky (psychiatrist) did an evaluation on client and said she was depressed. Mom had difficulty describing symptoms but client didn't want to go to school. Low self-esteem, low self-worth and hasn't had a lot of positive success, seeking attention anyway she can get it. Lying, sexting, attracted to unhealthy relational dynamics. Mom reports client is able to complete ADL's and doesn't necessarily isolate. The depression shows up more as "acting out behaviorally" risk taking behaviors and self-sabotage.

Self-harm: Onset 9th grade, parents got a call from school that client had pictures on snapchat that showed photos of her arms scratched / cut up and bleeding. Mom says last episode was a few weeks ago (Sept 17th), superficial cuts on arm / wrists with exacto-knife. Mom unsure of frequency but believes it's a few times a year.

Eating D/O (rule out): Mom reports that client will tell people that she is bulimic, but mom has never heard or seen client purge. Mom reports that client eats normally and has a normal appetite.

Family Issues / Attachment issues: Both client and sister are adopted, client adopted at birth although client did have to go into foster care for 5 days before parents could take her. Mom has been transparent with client about this since a very young age but mom reports that client "doesn't want to deal with it" according to mom. Client would say "I am not adopted." Mom believes that client still hasn't accepted it and likely the root cause of a lot of her issues. Client and sister are close but fight over typical sibling stuff (i.e. taking clothing etc.) Client will say she fights all the time with her mom and she just needs to get away from her. Mom reports she may have too high expectations of client, but feels client may have too low of expectations of herself. Mom feels most fights are due to client not following through on responsibilities or not following rule and boundaries. Mom reports client gets along with dad, but that sometimes client is disrespectful towards him.

Behavioral Acting out: Nov 6th grade, client stole money from dad's wallet and framed her sister to make it seem like her sister stole the money. After client's knee surgery, she told camp counselor that her parents allowed a boy her age stay in her room and molest her which is a lie according to mom. Client has taken sister's car and went for a "joy-ride." Client has also been engaging in sexting and promiscuous behavior, dressing in an attention seeking way. Client texted a picture of a pregnancy test to friends, which got back to the school.

Precipitating Events:

Client is struggling with psycho-somatic symptoms where she will have intense back spasms and episodes of numbness, tingling in legs and fingers and back spasms. Client has experienced "temporary blindness" as well during these episodes and paralysis. Mom reports that client will go into a "catatonic like state" and that this is happening every other week or so. Client has also been engaging in risk taking behavior and attention seeking behavior (sexting etc.). It was also reported to the school that client was smoking and drinking at school – schooled called mom to notify. Client reporting recent sexual assault. School therapist recommended residential treatment for client as client is continuing to decompensate despite outpatient therapy and medication. Client is need of a higher level of care at this time.

Medical Conditions:

Summer of 6th grade, client fell off a horse at camp, tore her meniscus. Knee Surgery: Summer of 7th grade.

Middle of 8th grade: diagnosed with Scoliosis (atypical idiopathic) – Client had to wear a back brace to school. Had to undergo spinal injections. Eventual surgery: Jan 2018: had rods put in her back.

Sept 8th: Client hit her head on a column during dance, had a concussion.

Treatment History:

2018: Psychotherapy: Keeley Bailey (EMDR): Mom reports that client sees her weekly.
2016 – Current: Psychiatrist // Dr. Suzanne Starky // medication management

Meds:

1. Zoloft: 200mg (Two 100mg tablets QHS)
2. Adderall Extended Release (Amphetamine Salts ER): 25mg 1 capsule in AM

3. Adderall 10mg: Takes 2 capsules ONLY IF NOT TAKING THE EXTENDED RELEASE and takes this for short-term need (for a tutoring session that lasts 4 hours)
4. Birth Control
5. Flonase nasal spray as needed for allergies or congestion (PRN).

Supplements as stated on the bottle for dosages:

1. Calcium 4 pills total per day. QAM QHS (2 am, 2pm),
2. Magnesium 2 total in AM

_X__Outpatient ____ Inpatient __X__Psych Hospitalization _X__ Family Therapy _X__ Ind. Therapy

Substance Abuse:

Mom denies drug abuse, alcohol or nicotine addiction.
Mom reports client has probably tried all but doesn't feel client is addicted. Client has told her that she's passed the "vaping" stage.

Please check-in with client for additional details.

General Functioning:

Baseline: Generally a happy kid when there is no stress, as soon as stress or pressure builds, client starts experiencing anxiety. As soon as there are expectations or when client feels that she cannot meet expectations, that's when things fall apart.

Current: Client is struggling with psycho-somatic symptoms where she will have intense back spasms and episodes of numbness, tingling in legs and fingers. Client has experienced "temporary blindness" as well during these episodes and paralysis. Mom reports that client will go into a "catatonic like state" and that this is happening every other week or so. Client is also engaging in risk taking behavior and attention seeking behavior. She experiences anxiety, depression and is reporting recent sexual assault.

Sleep: Approx a year ago, client had difficulty sleeping and would wake up every evening and go into her parent's room or her mother would sleep in her bed. She said she felt "afraid" but was not in touch with what was causing fear. Last two weeks, client having difficulty staying asleep but seems to fall asleep ok.

Appetite: Healthy eater, although client will say that she's "bulimic" according to mom. Mom reports that client eats normally and mom has never seen or heard her purge. Mom finds it hard to believe that client is truly bulimic.

School:
Baseline: Client has always experienced anxiety with going to school. She was diagnosed with ADHD in 1st grade and medicated. Mom reports client was always a B / C student, although smart enough to make B's. Mom reports she starts out doing well but then gets tired of going etc.. grades start to slide. Motivation begins to wane. Transferred from private school to public school in 4th grade.

Current: Client has missed a lot of schooling due to medical issues and surgery. She has managed to stay on track and has been getting B's.

Trauma History:

- Possible sexual assault: Parents took client and friend to movie theatre. Parents went into a different movie and client and friend saw another movie. After parents movie ended, mom went into theatre to check on client and friend, she found her friend sitting alone and client was sitting between two boys in movie theatre and was making out. When she got to school the next day, client told friends the story and friends were saying she was assaulted. Client then told the school counselor she was assaulted and then the sheriff had to be called. Charges have not been filed but client has been seeing her therapist to process this.

- Possible trauma: (6th grade) Client was with her friend and stopped in at friend's grandmother's nursing home. Grandmother died at that exact time when they were visiting. Client watched her die.

- Medical issues. Spinal surgery

Risk Event History:

Client claims she has snuck out of the house although parents never caught her.
Telling people things that are not true (lying) for attention. Mom states that client has told people that mom is an alcoholic and abusive. Mom reports this is not true.
Client took sister's car and went on a "joy ride."
Client engaging in sexting behaviors.

Suicide Attempts:

None

Relationship History / Identity:

Sexual Orientation: Heterosexual
Gender Identity: Female

Mom reports there is a boy named "Josh" who is her age and he has a 1 year-old baby. Josh lives two hours away and is in juvenile jail. Client is telling "the world" that he is her boyfriend. Fascination / fixation there according to mom, where client is attracted to unhealthy relationships or seeks attention.

Legal Issues:

None

Family History:

Maternal:

- Bio-mom - unsure
- Adoptive mom has had breast cancer, which "shook" client – 3 years recovering from breast cancer.
-

Paternal:

- Unknown

Client's Strengths:

Drawing; singing; dancing, cheer, softball, track, swimming, golf.

Very personable, great memory recall with names, people person but can be a people pleaser, loves to help others, good heart.

Client's Goals:

"To feel better.." See bio-psych.

Family Involvement:

Parents and sister

Allergies:

NKDA / NKFA

Thoughts about Discharge:

TBD

Other:

MMPI®-A
Minnesota Multiphasic Personality Inventory®– ADOLESCENT

Inpatient Mental Health Interpretive Report

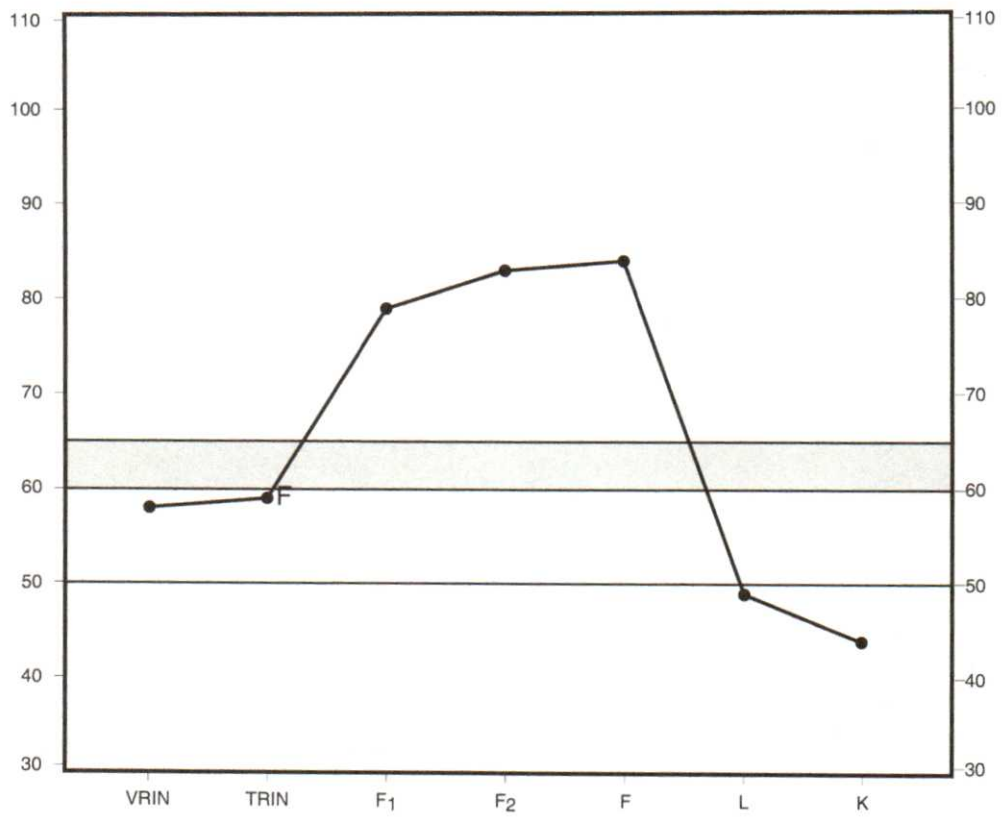
MMPI®-A
The Minnesota Report™: Adolescent Interpretive System, 2nd Edition
James N. Butcher, PhD, & Carolyn L. Williams, PhD

Name:	Campbell Hatch
Age:	16
Gender:	Female
Administration Language:	English
Date Assessed:	10/04/2018

PsychCorp

[4.6 / 1 / QG]

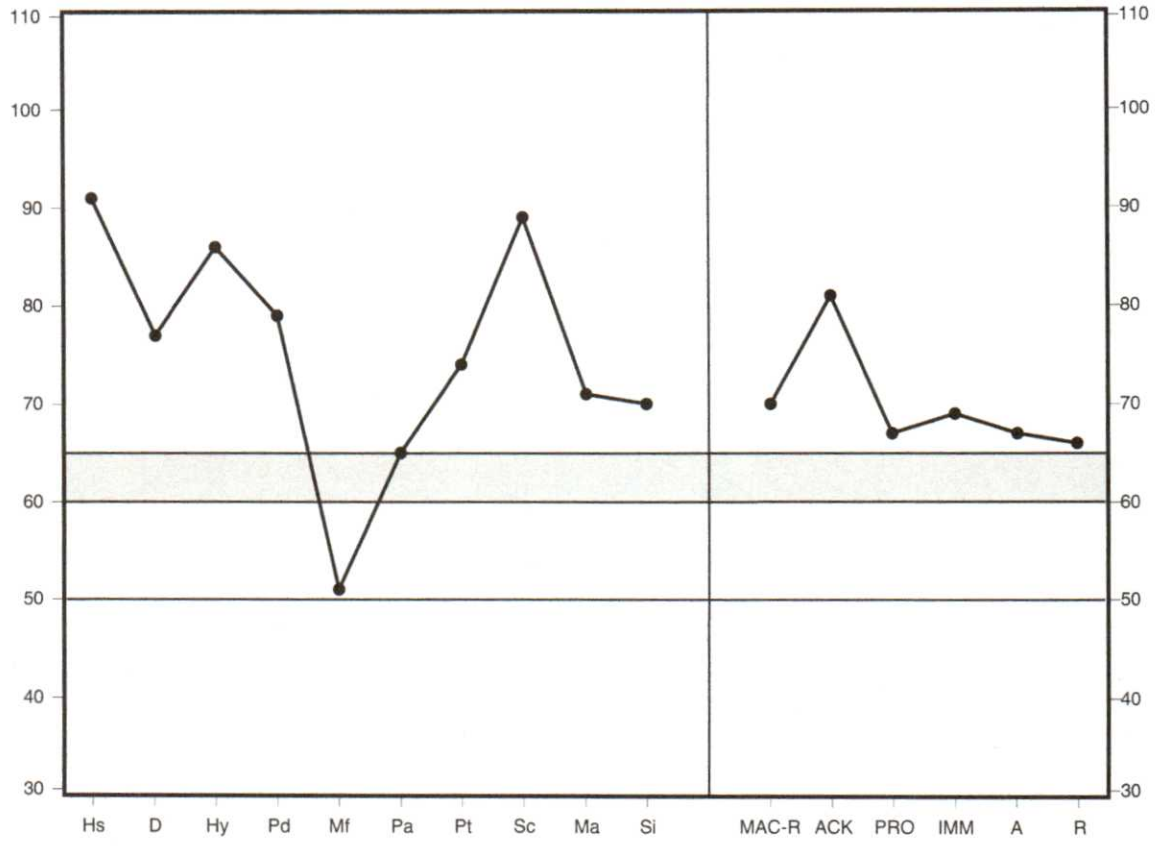
MMPI-A VALIDITY SCALES PROFILE



	VRIN	TRIN	F_1	F_2	F	L	K
Raw Score:	6	8	12	20	32	2	9
T Score:	58	59	79	83	84	49	44
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw):	0
Percent True:	63
Percent False:	37

MMPI-A CLINICAL AND SUPPLEMENTARY SCALES PROFILE

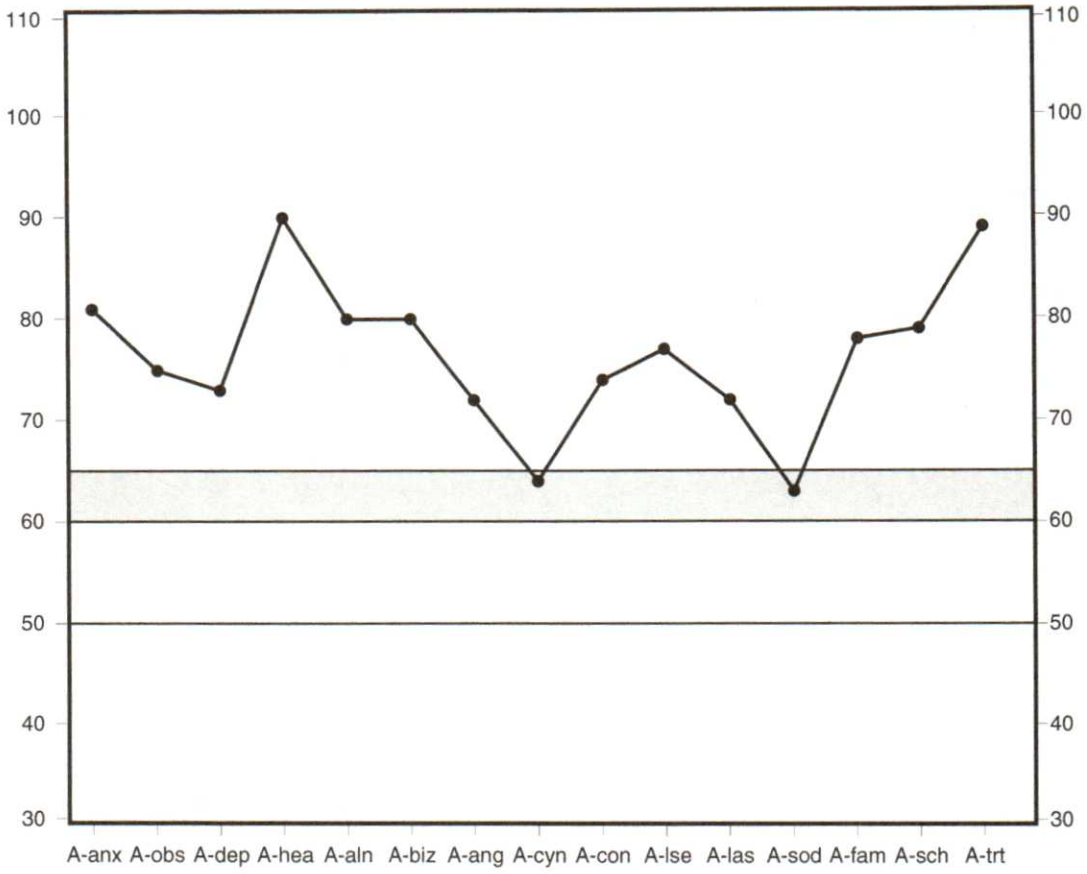


	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si	MAC-R	ACK	PRO	IMM	A	R
Raw Score:	28	35	39	34	28	19	37	54	30	43	28	11	24	24	30	19
T Score:	91	77	86	79	51	65	74	89	71	70	70	81	67	69	67	66
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Welsh Code: 1*83"42790'6+-5/ F"'+-/LK:

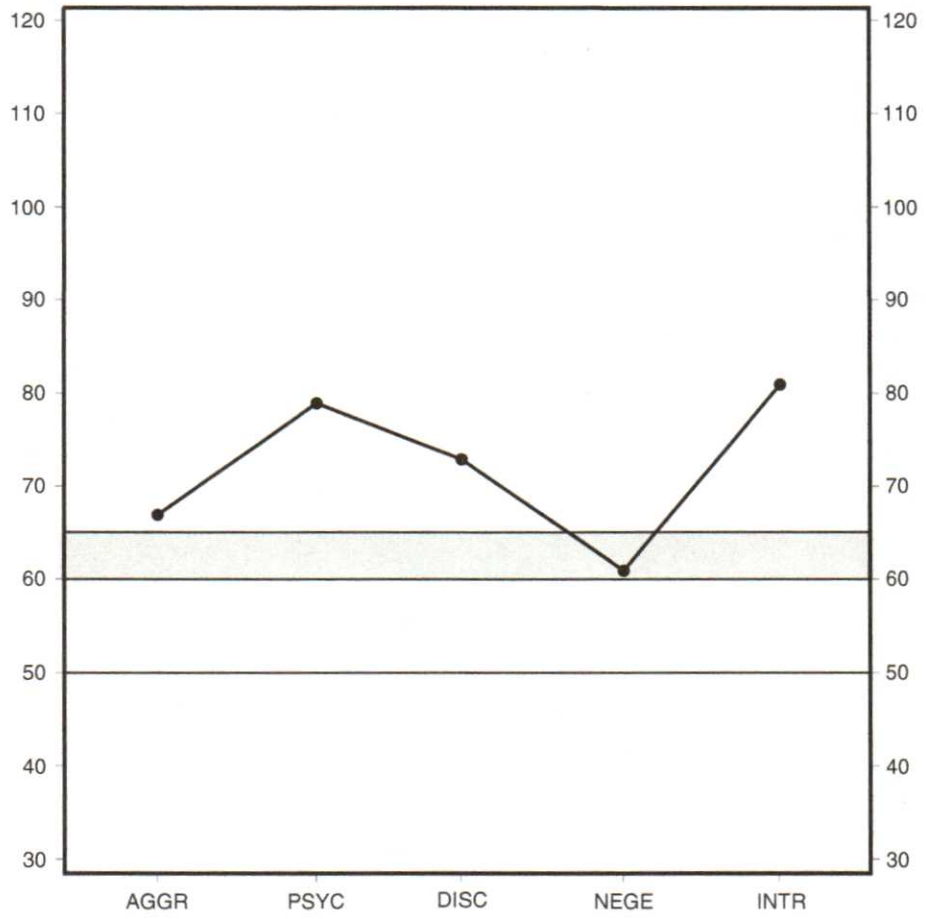
Mean Profile Elevation: 79.0

MMPI-A CONTENT SCALES PROFILE



Raw Score:	19	14	20	30	15	13	14	18	16	14	11	13	25	14	22
T Score:	81	75	73	90	80	80	72	64	74	77	72	63	78	79	89
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

MMPI-A PSY-5 SCALES PROFILE



	AGGR	PSYC	DISC	NEGE	INTR
Raw Score:	14	14	15	16	18
T Score:	67	79	73	61	81
Response %:	100	100	100	100	100

VALIDITY CONSIDERATIONS

Her responses to the MMPI-A items were more extreme and exaggerated than those of most adolescents. She endorsed a wide variety of extreme symptoms. These symptoms may include psychotic thoughts or behaviors, alcohol- or other drug-related problems, eating difficulties, extreme family discord, or problematic interpersonal relationships. She may be exaggerating her symptoms as a plea for help. It is also possible that poor reading skills contributed to her extreme responses. These responses could also have resulted from a confused, disoriented, or intoxicated state. The resulting MMPI-A protocol may not provide a clear indication of her personality and symptoms and should only be interpreted after consideration of the likely reasons for this exaggerated response style.

Her score on VRIN, however, suggests that she was quite consistent in her endorsement of the MMPI-A items. She appeared to take into account item meaning when selecting her extreme responses.

SYMPTOMATIC BEHAVIOR

Adolescents with this MMPI-A clinical profile tend to show a pattern of psychological maladjustment. Internalization of conflict is characteristic of many adolescents with this clinical pattern. This adolescent is probably experiencing severe personality deterioration and is likely to have problems with intense anxiety, somatic distress, and agitation. She may also have many problems because of her general ineffectiveness in dealing with life.

She is likely to demand a great deal of attention for her somatic complaints, which may have a bizarre quality, and she may be delusional about her health. She may appear somewhat suspicious and mistrustful.

Her high-point MMPI-A score, Hs, is the lowest frequency peak score among adolescent girls in treatment settings. Only about 2% of girls in treatment programs have this peak scale elevation in their clinical profile. It should be noted that this high-point score occurs with somewhat greater frequency (9%) as a peak score for girls in the normative population but at a lower level of elevation than in treatment program samples.

In a large Pearson Assessments archival sample of adolescent girls (n = 12,744), only 2.1% had a well-defined elevated Hs scale as their most frequent peak score at or above a T score of 65 and more than 5 points separating it from the next highest scale.

Extreme responding is apparent on her MMPI-A Content Scales profile. She endorsed at least 90% of the items on A-anx and A-obs in the deviant direction, indicating that the following is quite important in understanding her problem situation. She reported many symptoms of anxiety, tension, and worry. She may have frequent nightmares, fitful sleep, and difficulties falling asleep. Life is very much a strain for her and she may feel that her problems are insurmountable. A feeling of dread is pervasive as are difficulties with concentration and staying on task. She reports worrying beyond reason, often over trivial matters. She may be troubled by intrusive thoughts (for example, "bad words") or by counting unimportant things. Her sleep may be disturbed by worries. Decision making is problematic and she approaches changes with dread.

In addition to the extreme endorsements found in her MMPI-A Content Scales profile, she also described other important problem areas. She reports numerous somatic symptoms, including gastrointestinal difficulties, neurological problems, sensory deficits, cardiovascular symptoms, pain, or respiratory problems.

She reports several strange thoughts and experiences, which may include hallucinations, persecutory ideas, or ideas of reference. She described significant behavioral problems including stealing, lying, destroying property, and swearing. These problems are likely to cut across settings, including school and home. She may be assaultive or aggressive when she is angry, and she may be overly interested in violence. She reported numerous problems in school, both academic and behavioral. She has limited expectations of success in school and is not very interested or invested in succeeding. Symptoms of depression were reported. She endorsed several very negative attitudes about herself and her abilities.

Although adolescents with this MMPI-A high point may emphasize physical problems, she has also acknowledged some personality characteristics on the PSY-5 scales that likely impact her adjustment. She shows little capacity to experience pleasure in life. Persons with high scores on the Introversion/Low Positive Emotionality scale can be pessimistic, anhedonic (unable to experience pleasure), and socially withdrawn with few or no friends. Her pervasive physical problem presentation could result, in part, from this characteristic personality style. She may also hold some unusual beliefs that may lead her to misinterpret events and others' intentions. Her high score on the Psychoticism scale suggests that she often feels alienated from others and might experience unusual symptoms such as circumstantial and tangential thinking.

INTERPERSONAL RELATIONS

Her interpersonal relationships are probably disturbed, and she tends to manipulate others by developing physical symptoms.

She is a very introverted person who has difficulty meeting and interacting with other people. She is shy and emotionally distant, and she tends to be very uneasy, rigid, and overcontrolled in social situations. Her shyness is probably indicative of a broader pattern of social withdrawal. She is probably very timid and avoids relating to the opposite sex. She may feel weak and uncoordinated. She is probably fearful and depressed. She may think about suicide in response to the problems she has being around others. Although alcohol- and drug-use problems are unusual in an introverted adolescent, she admitted problematic use of alcohol, marijuana, or other drugs. Drug use may serve as a coping strategy for handling her social anxiety. Her MMPI-A indicates a tendency to develop problems with alcohol or other drugs. However, given her introversion, it is unlikely that she is an active member of a drug-using peer group. Further evaluation is indicated.

Some interpersonal issues are suggested by her MMPI-A Content Scales profile. She reports considerable discord within her family. She characterizes her family as angry, jealous, and fault finding. She reports increasing disagreements with her parents and worsening arguments between her parents. Her family problems may spill over into other settings (school, for example).

She reports being irritable and impatient with others, and she may throw temper tantrums to get her way.

This young person reports feeling distant from others. Other people seem unsympathetic toward her. She feels unliked and believes that no one understands her. She reports several problems in social relationships. She finds it difficult to be around others, and she prefers to be alone. She reported some misanthropic attitudes, indicating distrust of others and their motivations. She may be on guard when people seem friendlier than she thinks they should be.

BEHAVIORAL STABILITY

The relative scale elevation of the highest scales (Hs, Hy, Sc) in her clinical profile reflects high profile definition. If she is retested at a later date, the peak scores on this test are likely to retain their relative salience in her profile pattern.

Adolescents with this clinical profile often develop persistent adjustment problems. This adolescent's present extreme pattern of physical symptoms may have been precipitated by environmental stress. Her premorbid adjustment may have been poor, however, and the present agitated state is likely to be only an intensification of previous problems.

DIAGNOSTIC CONSIDERATIONS

Her clinical profile suggests consideration of a serious mental disorder, such as schizophrenia or severe anxiety disorder.

She reported several bizarre thoughts and behaviors. If these experiences cannot be explained by alcohol or other drug intoxication, organic problems, a misunderstanding of the items, or an intentional exaggeration of psychopathology, a psychotic process should be considered.

Given her elevation on the School Problems scale, her diagnostic evaluation could include assessment of possible academic skills deficits and behavior problems. Academic underachievement, a general lack of interest in any school activities, and low expectations of success are likely to play a role in her problems. Her extreme endorsement of multiple anxiety-based symptoms should be considered in her diagnostic work-up. Recurrent obsessions, including obsessive brooding, may be a part of her diagnostic picture.

She appears to be having difficulties that may involve the use of alcohol or other drugs.

She has endorsed items that confirm her increasing involvement with alcohol or other drugs. She acknowledges that her use is problematic and reports being criticized for it. She may feel that alcohol or other drugs facilitate social interactions, thus serving as a coping strategy.

TREATMENT CONSIDERATIONS

Adolescents with this MMPI-A clinical profile tend to be experiencing unexplainable and bizarre physical symptoms. They tend to be quite eccentric and have unusual thinking about their bodily processes. There is a strong possibility that this adolescent has a thought disorder that prevents her from understanding her problems. She is likely to be uninsightful about possible psychological factors involved in her problems. She is not likely to be open to insight-oriented psychological treatment for her problems, and insight-oriented or nondirective therapy would probably be unproductive in her case. Behavior modification procedures may be used to alter her unusual symptom pattern.

Her very high potential for developing alcohol or drug problems requires attention in therapy if important life changes are to be made. She has acknowledged some problems in this area, which is a valuable first step for intervention.

She should be evaluated for the presence of suicidal thoughts and any possible suicidal behaviors. If she is at risk, appropriate precautions should be taken.

Her family situation, which is full of conflict, should be considered in her treatment planning. Family therapy may be helpful if her parents or guardians are willing and able to work on conflict resolution. However, if family therapy is not feasible, it may be profitable during the course of her treatment to explore her considerable anger at and disappointment in her family. Alternate sources of emotional support from adults (e.g., foster parent, teacher, other relative, friend's parent, or neighbor) could be explored and facilitated in the absence of caring parents.

Conditions in her environment that may be contributing to her aggressive and assaultive behaviors could be explored. Adolescents with anger-control problems may benefit from modeling approaches and rewards for appropriate behaviors. Stress-inoculation training or other cognitive-behavioral interventions could be used to teach self-control. Observations of her behavior around her peers may provide opportunities to intervene and prevent aggressive actions toward others.

She may have several attitudes and beliefs that could interfere with establishing a therapeutic relationship. These may include very negative opinions about mental health professionals, an unwillingness to self-disclose, and beliefs that her problems are unsolvable. She may be unwilling to accept responsibility for her behaviors or to plan for her future. She may doubt that others care enough to help her or that they are capable of understanding her.

This adolescent's emotional distance and discomfort in interpersonal situations must be considered in developing a treatment plan. She may have difficulty self-disclosing, especially in groups. She may not appreciate receiving feedback from others about her behavior or problems.

ADDITIONAL SCALES

A subscale or content component scale should be interpreted only when its corresponding parent scale has an elevated T score of 60 or above. Subscales and content component scales printed below in bold meet that criterion for interpretation.

	Raw Score	T Score	Resp %
Harris-Lingoes Subscales			
Depression Subscales			
Subjective Depression (D_1)	**21**	**74**	**100**
Psychomotor Retardation (D_2)	**8**	**67**	**100**
Physical Malfunctioning (D_3)	**8**	**77**	**100**
Mental Dullness (D_4)	**10**	**73**	**100**
Brooding (D_5)	**7**	**65**	**100**
Hysteria Subscales			
Denial of Social Anxiety (Hy_1)	3	48	100
Need for Affection (Hy_2)	4	46	100
Lassitude-Malaise (Hy_3)	**15**	**87**	**100**
Somatic Complaints (Hy_4)	**14**	**79**	**100**
Inhibition of Aggression (Hy_5)	2	43	100
Psychopathic Deviate Subscales			
Familial Discord (Pd_1)	**7**	**66**	**100**
Authority Problems (Pd_2)	4	59	100
Social Imperturbability (Pd_3)	3	49	100
Social Alienation (Pd_4)	**8**	**62**	**100**
Self-Alienation (Pd_5)	**11**	**75**	**100**
Paranoia Subscales			
Persecutory Ideas (Pa_1)	**7**	**61**	**100**
Poignancy (Pa_2)	**8**	**73**	**100**
Naivete (Pa_3)	2	41	100
Schizophrenia Subscales			
Social Alienation (Sc_1)	**14**	**73**	**100**
Emotional Alienation (Sc_2)	**6**	**70**	**100**
Lack of Ego Mastery, Cognitive (Sc_3)	**9**	**76**	**100**
Lack of Ego Mastery, Conative (Sc_4)	**10**	**71**	**100**
Lack of Ego Mastery, Defective Inhibition (Sc_5)	**10**	**77**	**100**
Bizarre Sensory Experiences (Sc_6)	**14**	**75**	**100**
Hypomania Subscales			
Amorality (Ma_1)	**4**	**63**	**100**
Psychomotor Acceleration (Ma_2)	9	59	100
Imperturbability (Ma_3)	3	50	100
Ego Inflation (Ma_4)	5	52	100

	Raw Score	T Score	Resp %
Social Introversion Subscales			
Shyness / Self-Consciousness (Si_1)	7	52	100
Social Avoidance (Si_2)	**6**	**72**	**100**
Alienation--Self and Others (Si_3)	**15**	**68**	**100**
Content Component Scales			
Adolescent Depression			
Dysphoria (A-dep_1)	**4**	**64**	**100**
Self-Depreciation (A-dep_2)	3	55	100
Lack of Drive (A-dep_3)	**6**	**71**	**100**
Suicidal Ideation (A-dep_4)	**3**	**70**	**100**
Adolescent Health Concerns			
Gastrointestinal Complaints (A-hea_1)	**4**	**82**	**100**
Neurological Symptoms (A-hea_2)	**15**	**82**	**100**
General Health Concerns (A-hea_3)	**6**	**76**	**100**
Adolescent Alienation			
Misunderstood (A-aln_1)	**5**	**69**	**100**
Social Isolation (A-aln_2)	**5**	**79**	**100**
Interpersonal Skepticism (A-aln_3)	**4**	**74**	**100**
Adolescent Bizarre Mentation			
Psychotic Symptomatology (A-biz_1)	**10**	**82**	**100**
Paranoid Ideation (A-biz_2)	1	55	100
Adolescent Anger			
Explosive Behavior (A-ang_1)	**6**	**68**	**100**
Irritability (A-ang_2)	**8**	**66**	**100**
Adolescent Cynicism			
Misanthropic Beliefs (A-cyn_1)	10	58	100
Interpersonal Suspiciousness (A-cyn_2)	**8**	**65**	**100**
Adolescent Conduct Problems			
Acting-Out Behaviors (A-con_1)	5	58	100
Antisocial Attitudes (A-con_2)	**7**	**72**	**100**
Negative Peer Group Influences (A-con_3)	**3**	**76**	**100**
Adolescent Low Self-Esteem			
Self-Doubt (A-lse_1)	**10**	**73**	**100**
Interpersonal Submissiveness (A-lse_2)	**4**	**66**	**100**
Adolescent Low Aspirations			
Low Achievement Orientation (A-las_1)	5	58	100
Lack of Initiative (A-las_2)	**6**	**72**	**100**

	Raw Score	T Score	Resp %
Adolescent Social Discomfort			
Introversion (A-sod$_1$)	**10**	**76**	**100**
Shyness (A-sod$_2$)	3	46	100
Adolescent Family Problems			
Familial Discord (A-fam$_1$)	**17**	**71**	**100**
Familial Alienation (A-fam$_2$)	**6**	**69**	**100**
Adolescent School Problems			
School Conduct Problems (A-sch$_1$)	**2**	**65**	**100**
Negative Attitudes (A-sch$_2$)	**6**	**70**	**100**
Adolescent Negative Treatment Indicators			
Low Motivation (A-trt$_1$)	**9**	**75**	**100**
Inability to Disclose (A-trt$_2$)	**6**	**65**	**100**

Uniform T scores are used for Hs, D, Hy, Pd, Pa, Pt, Sc, Ma, the content scales, the content component scales, and the PSY-5 scales. The remaining scales and subscales use linear T scores.

ITEM-LEVEL INDICATORS

The MMPI-A contains a number of items whose content may indicate the presence of psychological symptoms when endorsed in the deviant direction. The MMPI-A critical item list includes 15 categories that may provide an additional source of hypotheses about this young person.

However, caution should be used when interpreting item-level indicators like the MMPI-A critical items because responses to single items are much less reliable than scores on full-length scales. An individual can easily mismark or misunderstand a single item, and not intend the answer given. Furthermore, many adolescents in the normative sample endorsed some of the MMPI-A critical items in the deviant direction. For this reason, the responses to the item-level indicators printed below include the endorsement frequency for the item in the normative sample to give the clinician an indication of how common or rare the response is in the general population.

Aggression
(Of the three possible items in this section, one was endorsed in the scored direction):

465. I don't like having to get "rough" with people.
(26.9% of the normative girls responded False.)

Anxiety
(Of the six possible items in this section, five were endorsed in the scored direction):

36. My sleep is fitful and disturbed.
(15.3% of the normative girls responded True.)
163. I am afraid of losing my mind.
(23.1% of the normative girls responded True.)
173. There is something wrong with my mind.
(12.5% of the normative girls responded True.)
309. Almost every day something happens to frighten me.
(14.9% of the normative girls responded True.)
353. I have nightmares every few nights.
(16.3% of the normative girls responded True.)

Cognitive Problems
(Of the three possible items in this section, one was endorsed in the scored direction):

158. My memory seems to be all right.
(11.9% of the normative girls responded False.)

Conduct Problems
(Of the seven possible items in this section, five were endorsed in the scored direction):

224. At times it has been impossible for me to keep from stealing or shoplifting something.
(11.7% of the normative girls responded True.)
345. My friends are often in trouble.
(24.6% of the normative girls responded True.)

440. I have spent nights away from home when my parents did not know where I was.
(26.2% of the normative girls responded True.)
445. I often get into trouble for breaking or destroying things.
(21.3% of the normative girls responded True.)
460. I have never run away from home.
(25.6% of the normative girls responded False.)

Depression/Suicidal Ideation
(Of the seven possible items in this section, five were endorsed in the scored direction):

62. Most of the time I feel blue.
(20.1% of the normative girls responded True.)
71. I usually feel that life is worthwhile.
(15.7% of the normative girls responded False.)
177. I sometimes think about killing myself.
(30.2% of the normative girls responded True.)
242. No one cares much what happens to you.
(17.9% of the normative girls responded True.)
399. The future seems hopeless to me.
(17.0% of the normative girls responded True.)

Family Problems
(Of the three possible items in this section, one was endorsed in the scored direction):

365. When things get really bad, I know I can count on my family for help.
(28.9% of the normative girls responded False.)

Hallucinatory Experiences
(Of the five possible items in this section, four were endorsed in the scored direction):

92. I see things or animals or people around me that others do not see.
(16.7% of the normative girls responded True.)
299. I hear strange things when I am alone.
(29.5% of the normative girls responded True.)
433. When I am with people, I am bothered by hearing very strange things.
(12.0% of the normative girls responded True.)
439. I often hear voices without knowing where they come from.
(16.6% of the normative girls responded True.)

Paranoid Ideation
(Of the nine possible items in this section, one was endorsed in the scored direction):

95. Someone has it in for me.
(19.2% of the normative girls responded True.)

School Problems
(Of the five possible items in this section, two were endorsed in the scored direction):

101. In school I have sometimes been sent to the principal for bad behavior.
(24.2% of the normative girls responded True.)
380. Often I have not gone to school even when I should have.
(22.4% of the normative girls responded True.)

Self-Denigration
(Of the five possible items in this section, four were endorsed in the scored direction):

90. Much of the time I feel as if I have done something wrong or evil.
(22.7% of the normative girls responded True.)
219. I believe I am a condemned person.
(12.0% of the normative girls responded True.)
230. I believe my sins are unpardonable.
(10.7% of the normative girls responded True.)
392. I deserve severe punishment for my sins.
(18.5% of the normative girls responded True.)

Sexual Concerns
(Of the four possible items in this section, two were endorsed in the scored direction):

31. I have never been in trouble because of my sex behavior.
(20.2% of the normative girls responded False.)
251. I wish I were not bothered by thoughts about sex.
(38.0% of the normative girls responded True.)

Somatic Complaints
(Of the nine possible items in this section, eight were endorsed in the scored direction):

113. I have never vomited blood or coughed up blood.
(26.7% of the normative girls responded False.)
138. I have never had a fit or convulsion.
(23.0% of the normative girls responded False.)
165. I frequently notice my hand shakes when I try to do something.
(25.6% of the normative girls responded True.)
169. My hands have not become clumsy or awkward.
(19.0% of the normative girls responded False.)
175. I have had attacks in which I could not control my movements or speech but in which I knew what was going on around me.
(13.3% of the normative girls responded True.)
214. I have had blank spells in which my activities were interrupted and I did not know what was going on around me.
(25.2% of the normative girls responded True.)
231. I have numbness in one or more places on my skin.
(13.0% of the normative girls responded True.)

275. I have never been paralyzed or had any unusual weakness of any of my muscles.
(25.4% of the normative girls responded False.)

Substance Use/Abuse
(Of the nine possible items in this section, eight were endorsed in the scored direction):

144. I have a problem with alcohol or drugs.
(13.6% of the normative girls responded True.)
161. I have had periods in which I carried on activities without knowing later what I had been doing.
(29.2% of the normative girls responded True.)
247. I have used alcohol excessively.
(22.2% of the normative girls responded True.)
342. I can express my true feelings only when I drink.
(14.2% of the normative girls responded True.)
429. I have some habits that are really harmful.
(28.9% of the normative girls responded True.)
431. Talking over problems and worries with someone is often more helpful than taking drugs or medicines.
(23.8% of the normative girls responded False.)
458. I sometimes get into fights when drinking.
(17.3% of the normative girls responded True.)
467. I enjoy using marijuana.
(22.9% of the normative girls responded True.)

Unusual Thinking
(Of the four possible items in this section, all were endorsed in the scored direction):

22. Evil spirits possess me at times.
(8.1% of the normative girls responded True.)
250. My soul sometimes leaves my body.
(8.4% of the normative girls responded True.)
291. I often feel as if things are not real.
(36.5% of the normative girls responded True.)
417. Ghosts or spirits can influence people for good or bad.
(27.5% of the normative girls responded True.)

This young person did not endorse any items from the following MMPI-A critical items category:

Eating Problems

End of Report

NOTE: This MMPI-A interpretation can serve as a useful source of hypotheses about adolescent clients. This report is based on objectively derived scale indexes and scale interpretations that have been developed with diverse groups of clients from adolescent treatment settings. The personality descriptions, inferences, and recommendations contained herein need to be verified by other sources of clinical information because individual clients may not fully match the prototype. Only a qualified, trained professional should use the information in this report.

This and previous pages of this report contain trade secrets and are not to be released in response to requests under HIPAA (or any other data disclosure law that exempts trade secret information from release). Further, release in response to litigation discovery demands should be made only in accordance with your profession's ethical guidelines and under an appropriate protective order.

ITEM RESPONSES

1: 2	2: 2	3: 2	4: 1	5: 1	6: 1	7: 2	8: 2	9: 2	10: 2
11: 1	12: 1	13: 2	14: 1	15: 1	16: 1	17: 1	18: 1	19: 1	20: 1
21: 1	22: 1	23: 2	24: 1	25: 1	26: 1	27: 1	28: 1	29: 1	30: 2
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471:	1	472:	1	473:	1	474:	2	475:	2	476:	1	477:	1	478:	1				